United States v. State of Texas

Monitoring Team Report

Denton Supported Living Center
July 22-26, 2013

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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

As always, 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, Wes Knox, Billy Hensley, Patty Artman, Devon Wince, Brenda Morris, and Lori Powell. 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 484 individuals.

Facility Self-Assessment. DSSLC continued to improve its process of assessing status of compliance. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. In particular, the Facility should analyze the findings to help prioritize actions and to identify areas needing more in-depth review.

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

Terminology
The term Qualified Intellectual Disability Professional (QIDP) had begun to replace the term Qualified Developmental Disability Professional (QDDP). Because the Facility staff were using both terms, and the replacement was not complete in all documents, this report will use the terms interchangeably.

Specific Findings

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

Restraints
The Facility had made continued progress in moving towards compliance in Section C. As noted in the last several reports a major barrier to additional compliance was various aspects of the administration and monitoring of medical restraints; however, the completeness and accuracy of restraint documentation had regressed from that observed at the last review.

- Positive Practices and Improvements Made
    - The Facility only had nine crisis intervention restraints over the last six months. The Facility experienced two months (12/12 and 3/13) in which no crisis intervention restraint of any type was necessary. The Facility did not

have any instances of use of Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB). The Facility is to be commended for reducing the use of crisis intervention restraint, and sustaining this reduction over time.
    - The Facility conducted routine auditing of restraint documentation, using standardized monitoring tools. Sampling was not necessary because the Facility only had nine crisis intervention restraints over the last six months. Each instance of restraint was individually audited.
    - The Facility had made significant progress in complying with some requirements associated with medical restraint. Still lacking was the consistent development of strategies and programs to minimize the need for medical restraint.
- Improvements Needed
    - Restraint Monitors occasionally were involved in the application of restraint. Staff involved in the application of restraint should not act as the Restraint Monitor for the same event.
    - 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 has most of the administrative systems in place to achieve compliance with Section D but needs to pay more attention to detail, identifying problems and mistakes, and taking aggressive actions to correct them and prevent recurrence. This was evident when comparing Provisions the Facility self-assessed as in compliance but the Monitoring Team did not find compliance.

- Positive Practices and Improvements Made
    - The number of confirmed findings of abuse and neglect had decreased significantly from 20 to eight, comparing the 12 month period ending June 2013 with the period ending June 2012.
    - The Facility demonstrated 100% compliance with the staff training requirements associated with abuse, neglect, and exploitation, and unusual incidents.
    - Reporting procedures were prominently displayed throughout the Facility and are printed on the back side of employee identification badges.
    - The DFPS Supervisor who oversees Facility investigations regularly participates in New Employee Orientation at the Facility.
    - In every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no direct contact status.
    - The audit procedure required by DADS to detect under-reporting of significant incidents had been in place at the Facility and was being administered correctly.
    - Compliance with required background checks was confirmed.
    - The Facility process for review of DFPS investigation reports had improved compared to what was observed at the last review. The Facility experienced continued improvement 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.

- Improvements Needed
  - While late reporting of allegations of abuse, neglect, and serious incidents had improved compared to that noted in the last report, it is still occurs too often. On a positive side the Facility now self-identifies most of these. The Monitoring Team found only one instance of a late report which was not self-identified.
  - The thoroughness and completeness of Facility review of facility investigations of UIRs had improved from that observed at the last review but was still not sufficient to ensure content of investigations was thorough and complete and that the report is accurate and complete.
  - The thoroughness and completeness of DFPS investigations remains an occasional problem. In one case with an inconclusive finding relevant witnesses weren't interviewed.
  - Investigations of serious discovered injuries had improved but too often conclude a "determined cause" with little or no evidence to support the conclusion. Often, 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.
  - Although staff training requirements were met, staff knowledge, when queried by the Monitoring Team, was variable.
  - Improvement is needed in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs).

Quality Assurance

The Facility demonstrated significant improvement in the development and implementation its QA system and has moved much closer to findings of substantial compliance than noted in previous reports. For example, QA activities noted in previous reports as "in the early stages of implementation" now appear to be routine and the number of monitoring tools that have inter-rater reliability had increased.

- Positive Practices and Improvements Made
  - The Facility QA Director and Settlement Agreement Coordinator meet monthly with each SA Section lead to review data, identify trends, and determine if Corrective Action Plans (CAPs) are needed.
  - The reports prepared by the QA department for the QA/QI Council are extensive and provide much useful data for review, analysis, discussion, and decision-making. Additionally, section leads also prepare narrative information for each report that includes: accomplishments for the last three months; upcoming challenges and plans for overcoming these challenges; data analysis; review of corrective action plan(s); status of policy/procedure review, revisions, and implementation; summary of any relevant committee recommendations; and priorities for the next quarter.

- The Facility developed key indicators (process and outcome) and tracks and trends data related to expected performance. The QA/QI Council regularly reviews key indicator data. The Facility's data system had achieved a level of maturity such that multiple variables can be examined for most data points.
- During a QA/QI Council meeting observed by the monitoring team, there was active and appropriate participation of attendees. A spirit of teamwork was evident to the Monitoring Team.

- Improvements Needed.
  - The process for inter-rater reliability continues to make progress but is not yet complete. Data tables and graphs presented in the monthly QA/QI Council report included inter-rater reliability data.
  - The Facility processes for initiating, implementing, and tracking CAPs had become more organized than that observed at the last review, but there are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems.
  - There was not an adequate system for tracking the status of CAPs. Of the CAPs being tracked by the Facility, none included any action taken if a CAP had not been implemented fully or timely.
  - Evidence showing how each CAP was evaluated for effectiveness was not apparent.

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

The Facility was undertaking a significant effort to improve on its processes to better support individual understanding of and participation in the ISP process. The goal of this process was to ensure the individual and the team work together in developing a service plan that is person centered. All QDDPs had received training related to this process. The Monitoring Team commends this overall initiative and believes it holds promise toward achieving compliance with this provision and, more importantly, for supporting individuals to participate fully in planning for their own futures. In addition, The Monitoring Team observed there was progress in the actual timely completion of the QDDP monthly reviews and the substance of the recent monthly notes. The Facility continued to take and/or plan actions designed to promote accessibility and comprehensibility of the ISP. Finally, the Facility was to be commended for its efforts toward developing a comprehensive quality assurance system for this Section.

- Positive Practices and Improvements Made
  - A revised ISP format and process had been implemented and considerable training and coaching had been provided to the QDDPs and IDTs. The new process included an ISP Preparation meeting held approximately three months prior to the ISP annual meeting as a means of ensuring adequate IDT preparation for the latter. The Monitoring Team found this to be a particularly promising practice that had already resulted in improved preparation and participation by IDT members as observed in the annual ISP meetings held during this site visit.
  - The Facility was to be commended for its efforts toward developing a comprehensive quality assurance system for this Section.
- Improvements Needed
  - IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
  - ISPs still did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.
  - Skill acquisition programs were not yet sufficiently constructed or assessed for progress.

- The Monitoring Team found ISP strategies still did not reflect encouragement of community participation in any meaningful or purposeful manner.

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, and there was evidence of integrated clinical services both through committees that reviewed care for individuals and through routine involvement of different disciplines in specific areas of services. Nevertheless, integrating planning and services across disciplines remained a challenge.

- Positive Practices and Improvements Made
  - The facility policy on Integration of Clinical Services had been substantively revised to address assessment timeliness and quality, use of clinical indicators, and elements of data to be included in monitoring of treatments, interventions, and health status of individuals.
  - The Integrated Morning Report continued to evolve. The format of the meeting had been revised to include a standard agenda and schedule of presentations. There was a specified agenda for daily meetings, with specific weekly reports scheduled during the week. The meeting provided an excellent forum for communication across disciplines and to the IDTs of both issues in care of individuals and in systemic areas being addressed. Interdisciplinary discussion of individuals and issues occurred.
  - The Physical and Nutritional Management Team demonstrated integrated planning, and also involved the IDTs for individuals in the PNMT process.
- Improvements Needed
  - Attendance of clinicians from some disciplines at ISP annual planning meetings needs to improve.
  - Although the Consultation Report form, which had been revised, provided a process to facilitate documentation of review of recommendations from non-facility clinicians, it was not consistently completed, and documentation of referral to the IDT was not present.

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. Continued improvement had occurred, particularly in addressing system wide improvements.

- Positive Practices and Improvements Made

- Timeliness of assessments had continued to improve. When timeliness began to slip, the Facility identified that and addressed it effectively.
- Comprehensiveness of assessments, while not yet adequate to achieve compliance, had improved significantly in several clinical disciplines.
- The Facility was now routinely using clinical indicators to assess status of healthcare and identify areas of need for systemic actions. Many of these indicators were fully integrated into the key indicators used by the Facility for quality review.

- Improvements Needed
  - At an individual level, it was still not always clear that clinical indicators were well-defined, and that modification of treatments and interventions reflected the use of the indicators in identifying when changes in status required them. Furthermore, it was unclear that monitoring was done consistently and made full use of the information from clinical indicators.
  - DADS needs to complete revision of a 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 also used supplementary tools that IDTs could use in the risk assessment planning process.

- Positive Practices and Improvements Made
  - The Facility had initiated a Facility specific policy (CM 14) addressing its At Risk system.
  - 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.
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- Improvements Needed
  - The IDTs did not always consider the interrelationship between various risk conditions. The risk assessment process in place at the Facility did not always accurately assess risk and consider discipline specific clinical information, and the interrelationship with other clinical data, when reviewing risk.
  - While much improved from that noted at the last review the 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' health status based on medical history, treatment regimens, and other supporting clinical data that was noted.

Psychiatric Care and Services

Two provisions came into substantial compliance, all that had been in substantial compliance remained in that status, and progress was made in other areas.

- Positive Practices and Improvements Made
  - The Facility initiated a process to establish tracking for efficacy of psychiatric medications, by beginning deployment of PBSP addenda that identify how treatment efficacy will be assessed.
  - Monthly psychiatric medication reviews (PMRs) included integrated and substantive clinical discussion about diagnosis.
  - The Facility administered the Reiss Screen across the campus for all individuals who needed the screen and assured the psychiatric evaluations were provided for the individuals who screen positive for possible mental health disorders. The Facility also established a process for use of the Reiss Screen in response to behavioral changes in status.
  - The Facility completed its deployment of MOSES and DISCUS screens in response to individual's changing needs, and the Facility continued to provide administration of the screens at the intervals required for routine monitoring.
- Improvements Needed
  - The project to improve PBSPs by identifying how treatment efficacy will be assessed needs to be completed.
  - Improvement is still needed in providing individuals who require pre-treatment sedation with programs to reduce the need for such sedation.
  - Key psychiatric treatment information should be included in ISPs.

Psychological services

Observations, interviews, and record reviews were conducted on-site at DSSLC from 7/22/2013 through 7/26/2013. 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 built upon previous achievements and continued to make progress; at times, that progress was considerable. It also appeared that the Facility was working toward substantial compliance in a systematic and coherent manner. Although an extensive amount of work remained, it was suggested that current processes were effective.

- Positive Practices and Improvements Made
  - All Behavioral Services staff had obtained Board Certification as a behavior analyst or were actively pursuing certification.
  - The PBSP data was precise, well organized and adequate for assessing the effects of behavior interventions.
  - Assessment of environmentally based behavior had improved across many elements.
  - The provision of counseling services was sophisticated, evidence based, and targeted toward the unique needs of each individual served.

- Previously noted delays in reviewing, approving and implementing PBSPs were substantially shorter.
- PBSPs continued to evidence sophistication and met conditions for compliance across several areas measured.

- Improvements Needed
  - Although the testing of adaptive skills had substantially increased, efforts did not ensure that all individuals were provided with current assessments.
  - The Facility continued to experience difficulty in ensuring that intervention data were reliable.
  - DSP staff continued to demonstrate limited knowledge about PBSPs and implementation instructions.
  - Although in several examples there was adequate integration of behavior and psychiatric interventions, this quality was not consistently demonstrated across interventions for all individuals.

Medical Care

The Facility showed improvement and diligent efforts to comply throughout this section. This was particularly the case for Provision L3.

- Positive Practices and Improvements Made
  - Annual medical assessments are much more comprehensive, as is the PNMT process.
  - There have been enhanced efforts for follow-up on pneumonia, decubitus ulcers, and serious injuries.
  - Documentation practice has also significantly improved with regards to IPNs being written in the SOAP format, and enhanced documentation of action plans being provided for each diagnosed condition.
  - The Facility conducts regularly scheduled internal and external medical audits, to help assess the clinical performance of physicians. Action plans were developed, implemented, and completed.
  - The medical quality assurance program showed significant improvement. The Facility developed, and implemented a data-driven process to track, and trend medical outcome indicators, for the purpose of enhancing clinical care at the Facility. Outcome indicators were well considered, and include topics such as pneumonia, other respirator infections, fractures, and other injures, and management of diabetes, among many others. Data is maintained by a functional electronic database system, and regularly analyzed for trends. Data and trends analysis were reviewed as a component of the Facility's robust QA/QI program, and along with recommendations for process improvements, were incorporated into a comprehensive QA/QI report.
  - The Monitoring Team reviewed, and concurred with, the Facility's new policies for medical consultations and medical QA/QI, and is compliments the State Office for developing a robust policy to address many medical issues, as delineated by its new medical policy. Compliance will require that the policy become substantially implemented at the Facility.

- Improvements Needed

- The Facility must also review its process to ensure that indications for DNRs are clinically justifiable, and that the ethics committee and IDT assertively evaluate the necessity of a DNR, prior to initiating a DNR, and at least annually thereafter.
- The Facility must enhance the medical audit process by ensuring that medical management elements are developed for the most common and most serious medical conditions that occur in people with intellectual disability; that a sound sample of records are reviewed for each audit; and that the results of the audits are used by the Facility to help enhance and monitor physician performance. In addition to process, the audits should assess the quality of items being audited.
- The Facility's mortality review process improved since the last review; however, the Facility must enhance its process further, in order to ensure that meaningful recommendations occur and lead to systems improvements. Also, the clinical review must better assess all contributing factors that may have played a role in the death.
- There was evidence to support that the medical director utilizes the QA/QI report to develop processes to enhance clinical outcome. However, the Facility did not demonstrate that the process is yet structured and formalized enough so that issues needing to be addressed will routinely be evident and actions documented.

<u>Nursing Care</u>

The Nursing Department showed progressive progress in Section M Provisions, more so in some than others. For Provision M.2, the guidelines for admission, annual, and quarterly nursing assessments were recently revised and continuing to evolve toward compliance. The same was true for Provisions M.3 and M.5 due to recent revisions to the ISP, Integrated Risk Rating, and Integrate Heath Care Plan processes and forms. There were no provisions found to regress.

- Positive Practices and Improvements Made
  - If the requirements for staffing Hospital Liaison Nurses, Infection Control, and Emergency Response activities were standalone activities they would be considered in substantial compliance.
  - The Facility had a robust competency based educational program that tracked all required training to ensure the training was completed. There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed.
  - The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.
- Improvements Needed
  - Requirements for documentation and assessment of acute change of status and skin integrity showed progress but continue to need improvements,

- The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. These processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance.

Pharmacy Services and Safe Medication Practices

The Monitoring Team noted continued improvement in working towards substantial compliance for Section N of the Settlement Agreement. Further development has been made, as the Monitoring Team determined substantial compliance for Provisions N.5 and N.8. The Facility maintained substantial compliance with all previous sections that were determined at prior visits to be in substantial compliance. Given the recent hire of clinical pharmacist, the Monitoring Team is confident that the Facility will continue to enhance its QDRR process.

- Positive Practices and Improvements Made
  - The Facility continued to provide excellent review of new medication orders.
  - The Facility judiciously monitored polypharmacy, both at the systems and individual level.
  - MOSES and DISCUS were obtained regularly, and when clinically indicated; and were reviewed, and completed by the medical provider.
  - The Monitoring Team continues to be impressed by the Facility's Adverse Drug Reaction process, including follow up on ADRs that occurred while individuals were hospitalized.
  - The Facility continued to maintain an effective Drug Utilization Evaluation (DUE) process.
  - The Facility developed, implemented, and maintained a robust process to track, trend, analyze, and implement corrective action, when necessary, for medication variances. The Facility's database for tracking mediation variances is robust. There was evidence to indicate meaningful action steps to help mitigate medication variances in the future.
- Improvements Needed
  - The QDRR process did not adequately document clinical rationale, potential risks, benefits, efficacy, and, when clinically appropriate, alternative treatment options.
  - The Facility should consider a process to ensure that the legally authorized representative is made aware of any ADR that requires medical attention.

Physical and Nutritional Management

Many positives were noted within this Section. DSSLC continued to take steps forward with regards to 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 improved considerably and were noted to have become more

comprehensive and provided staff with detailed strategies to mitigate associated PNM risks. Accurate implementation of PNMPs and dining plans remained problematic.

- 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 PNMT 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 among not only all members of the PNMT but the IDT as well.
  - New Employee training was comprehensive and DSSLC provided annual or refresher trainings that focused on preventing aspiration and providing proper transfer and lifting.
- Improvements Needed
  - There was still not a clear consistent process in place to ensure staff were provided with individual specific training prior to working with those individuals who were at an increased risk. 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 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.
  - PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the meeting.
  - The system for monitoring implementation of PNMPs and dining plans needed improvement. DSSLC did not have a system in place in which information regarding the completion of monitoring forms and its related data could be pulled, analyzed and trended. 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.
  - There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized concerns. Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem. There was limited evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status as well as limited to no monthly review by the QDDP.
  - 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. Pathways to oral intake focused primarily on pleasure feedings and did not address the benefits of improved oral musculature.

Physical and Occupational Therapy

DSSLC continued to show overall improvement with services identified within this provision. While still requiring additional work, the assessments continued to improve and provided a more comprehensive review of the individual. Indirect Supports (i.e., PNMPs) showed significant improvement and did an admirable job in outlining the supports needing to be implemented by staff to mitigate risk.

- Positive Practices and Improvements Made
  - Assessments were completed in accordance to the schedule set forth by DSSLC.
- Improvements Needed
  - Although improved, assessments were not comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis. There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning, nor was there assessment as to the effectiveness of therapy supports or comparative analysis of health and functional status from the previous year.
  - Therapy services were not consistently integrated into the ISP. Direct Services were not consistently documented and did not provide comprehensive documentation regarding benefit of services as well discharge information sharing with the IDT.
  - There was no process in place to ensure OT/PT 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.
  - A formal monitoring system did not exist for the adequate monitoring of OT/PT supports.

Dental Services

The Monitoring Team compliments the Facility for its continued and significant improvements observed with dental services. The Facility has made significant strides with documenting practices, timeliness of annual assessments, providing emergency dental services, monitoring of individuals undergoing sedation, and enhancing the IRRF, and PNMP process.

- Positive Practices and Improvements Made
  - The overall quality of routine and emergency dental services has significantly improved, as individuals are assessed and provided treatment timely and effectively.
  - The Facility has reduced missed dental appointment.
  - There is close monitoring post-sedation at the infirmary.
- Improvements Needed
  - The Facility needs to ensure consistency with recommendations made on the PNMPs, IRRFs, and dental summaries.
  - There is a need to enhance the process for assessing the needs for various oral health care services, such as suction toothbrushing.
  - The dental office must ensure that an oral health care treatment plan is developed for the CLDP, and that oral health care indicators are monitoring, during the post move monitoring period. Dental services must also be identified, prior to the transfer of an individual.

- Monitoring, and documentation of monitoring, post-sedation at the living areas must be improved.
- Although there has been noted improvement in programs to minimize the need for pre-treatment sedation, further improvement is needed.

Communication

Overall, Speech Assessments continued to improve but needed additional improvement. Implementation of communication programs remained low, although there was improvement in one unit.

- Positive Practices and Improvements Made
  - DSSLC has filled all of their positions.
- Improvements Needed
  - Assessments lacked information regarding comparative analysis. While the assessments were rolling in nature, the comparative analysis was vague at times and did not fully provide status comparison.
  - Staff knowledge of how to form effective communication with the individuals was not evident at the home level.
  - Individuals identified as having decreased communication did not have their plans implemented as written or throughout the day when opportunities for increased communication were presented.
  - The ISP did not have communication interventions consistently integrated into the individual's daily routine.
  - General area Alternative and Augmentative communication (AAC) was either not utilized and/or was nonfunctional. DSSLC did not have a comprehensive monitoring system with corresponding guidelines that covered the presence and condition of the device, or implementation of the device.

Habilitation, Training, Education, and Skill Acquisition Programs

The Facility had demonstrated greater progress over all than had been noted during previous visits. It was noted that dividing responsibilities for Section S across multiple staff appeared to have facilitated some of this improvement. In addition, the recruitment of external consultation also served to refocus efforts toward the core elements of skill acquisition training. This refocusing was important as in the past the Facility had attempted to achieve great progress with limited organization and goals that were too broad. A continuation of efforts to enhance organization and focus, with attention to efficiency as well would likely prove beneficial to further efforts toward substantial compliance.

- Positive Practices and Improvements Made
  - The Facility had implemented the services of a BCBA in training staff in relation to skill acquisition and the review of skill acquisition programs.
  - Since the beginning of 2013, 232 individuals had been provided assessment of adaptive skills. These assessments had been completed using standardized instruments.

- The majority of elements of SAPs targeted for review reflected progress in comparison with previous site visits.
- The Facility reported that substantially greater skill acquisition training was occurring in the community.

- Improvements Needed
  - Although the use of standardized assessments of adaptive skills and intelligence had increased, there was little indication that the findings of these assessments were used in the development of skill acquisition programs. Information provided by the Facility did not reflect that the majority of skill acquisition programs were based upon adequate assessments or targeted needs specific to the individual.
  - The Facility had not demonstrated an effort toward ensuring that standardized assessments of adaptive skills were current or provided for all individuals newly admitted to the Facility.
  - Levels of functional engagement had not appreciably increased over levels observed two years previously. Furthermore, there continued to be residences at the Facility where functional engagement fell far below accepted levels, potentially placing individuals at risk.
  - Numerous data sheets for skill acquisition programs were not current or did not include data collected according to instructions in the program.
  - Several disciplines did not consistently provide assessment reports for ISP meetings within the required time parameters.

<u>Most Integrated Setting</u>

This Section was found to be not in compliance overall. A summary of noted progress included a sizeable increase in the number of referrals for transition and an emphasis on developing individualized community awareness plans to assist individuals to form their preferences about community living. The Facility had also drafted a one-page Plan to Support People to Live in the Most Integrated Setting of Their Choice, which provided additional detail as to the roles and responsibilities of the various staff. Progress was noted in implementation of the CLDP processes, including the addition of two new practices including a Pre-Placement Medical Chart QA Protocol, and a Pre-Placement Doctor to Doctor Contact Protocol. These practices were designed to ensure that medical and health care issues were adequately identified prior to transition and adequately communicated to the community living providers.

The Monitoring Team found there was progress in the implementation of the ISP process, particularly in one of the on-site ISP annual planning meetings, but significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning.

- Positive Practices and Improvements Made
  - The numbers of transitions to more integrated settings and of referrals had increased significantly.
  - Staff responsible for required Community Living Discharge Plans (CLDPs) were consistently identified.

- CLDPs were reviewed with individuals and their Legally Authorized Representatives (LARs) as appropriate, to facilitate their decision-making.

- Improvements Needed
  - DSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue its efforts toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
  - The IDT also often 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 continued to be 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 found deficiencies in the monitoring process during this particular Post Move Monitoring (PMM) visit and there was concern noted about the diligence of the PMM process.

<u>Consent</u>

A summary of noted progress included the Facility's continued development of its commendable capacity to provide advocates for individuals as an alternative to guardianship, The Monitoring Team also commends the Facility for its initiative in incorporating formal choice and decision-making training in its self-advocacy efforts. The Facility had begun to measure the impact this may have on the capacity of individuals to make informed choices in a small but meaningful way. The Facility had begun to implement a quality assurance process using the Integrated ISP Monitoring Tool for this Section, which should be valuable in efforts to reach substantial compliance.

- Positive Practices and Improvements Made
  - 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 was implementing its Guardianship Committee in a thoughtful and organized manner, as called for in the DADS Policy. The Monitoring Team commends the Facility for articulating the specific roles and responsibilities of the Guardianship Committee in the overall decision-making processes related to Guardianship and Advocacy.
  - The Monitoring Team commends the Facility for its ongoing initiative toward incorporating formal choice and decision-making training in its self-advocacy efforts. This included the implementation of a formal choice-making curriculum obtained from another state developmental disabilities agency.
- Improvements Needed

- 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.
- While it may prove to be useful, the draft Rights Assessment in use at DSSLC is not a currently accepted standardized tool for assessing decisional capacity, nor do the IDTs appear to be proficient in using it effectively as an assessment device. 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. The auditing process has come into substantial compliance.

- 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.
  - Records were accessible and secure from view.
  - The record audit system included a careful process for following through and ensuring corrective actions for issues identified during audits were completed.
- Improvements Needed
  - 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.
  - A few requirements of Appendix D remained problematic. For some, systemic improvement actions had not yet been effective.
  - Observations by the Monitoring Team and the Facility found that information from records was not consistently used in making decisions.
  - 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 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	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 3. DSSLC Presentation Book (undated) 4. DADS Policy 001.1: Use of Restraint 4/1/12 5. DSSLC Policy CMGMT-20 Use of Restraint 6/1/12 6. Addendum D to DSSLC Policy CMGMT-24 Dental Services Procedure 4/19/13: Strategies to Reduce Medical/Dental Restraint 7. Dental Services DS-24 IV Sedation Policy 8/1/11 8. DADS Nursing Protocol: Post Anesthesia Care, June 2010 9. DADS Nursing Protocol: Pre-treatment and Post-Sedation Monitoring, December 2012 10. PMAB Training Curriculum Training Curriculum for RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) and RES0110 (Applying Restraint Devices) undated 11. Sample of staff training records (Sample C.2) 12. Restraint log for crisis intervention restraints 10/1/12 to 4/30/13 13. Restraint log for medical restraints 10/1/12 to 4/30/13 14. Restraint documentation files for sample (Sample C.1) of 11 crisis intervention restraints that occurred since the last review, 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 #127, #214, #110, #60, and #231 15. Restraint documentation files for sample (Sample C.3) of medical restraint for Individuals #222(3/7/13), #299(3/6/13), #368(2/12/13), #371(3/28/13), #482(2/8/13), #526(1/8/13), #572(4/25/13), #706(1/10/13), #761(2/27/13), #759(4/4/13), and#774(3/7/13) 16. Documentation for Individual #127, who was restrained more than three times in a rolling 30-day period. 17. List of Restraint Monitors and training transcripts 6/6/13 18. DSSLC Restraint Monitoring training material 2/12/13 19. Restraint Trend Analysis 6/13 **People Interviewed:** 1. Trenton Berrie, BCBA, Section C Lead 2. Randy Spence, Director of Behavioral Services 3. Elaine Davis, Competency Training & Development (CTD) Director 4. Scot Moore, Senior Training Specialist 5. Nine Direct Care Professionals (DCP's) from Timberhill and Garden Ridge residential areas **Meetings Attended/Observations:**

	1. Incident Management Review Team (IMRT) 7/24/13 2. Unit Review meeting 7/24/13 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 7/24/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C. 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. For Section C, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included those developed by DADS with the Facility to monitor Section C of the Settlement Agreement (SA). o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools: Psychology Assistants and QA Program Auditors. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools but was not reported in the self-assessment document. ▪ Used other relevant data sources and/or key indicators/outcome measures, such as reviewing Facility policy to ensure alignment with SA requirements, reviewing training delinquency reports, reviewing employee/restraint monitor training transcripts, and conducting competency checks with employees. ▪ The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment clearly described what was being assessed, how the assessment occurred, and data associated with its findings. o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline.

	▪ The Facility rated itself as being in compliance with Provisions C.2, C.7, and C.8 of the SA. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following provisions: Provisions C.1 and C.2. The lack of compliance with Provisions C.1 and C.3 in the last review was primarily attributable to deficient practices with medical restraint. The Monitoring Team is now reviewing medical restraint exclusively under Provisions C.4 and C.5. Provision C.3 was not in compliance because staff training did not result in staff being able to demonstrate understanding of basic restraint policy. Most sub-sections of Provision C7 were in compliance, but there was still a need to ensure the treatment plan is implemented with a high level of treatment integrity. Restraint review practices required under Provision C.8 were not consistently detecting documentation errors causing this previously compliant Provision to lose its substantial compliance rating. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as either completed or in process. ▪ The Facility data identified areas of need/improvement. Generally, the discussion of the results of the self-assessment included narrative description of the operational issues, based on monitoring data, which needed improvement. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. For example, continued refinement of restraint related training curriculum, especially with regard to medical restraint.
	Summary of Monitor's Assessment: The Facility had made continued progress in moving towards compliance in Section C. As noted in the last several reports a major barrier to additional compliance was various aspects of the administration and monitoring of medical restraints; however, the completeness and accuracy of restraint documentation had regressed from that observed at the last review. The Facility only had nine crisis intervention restraints over the last six months. The Facility reported no use of chemical restraint for crisis intervention since the last review and experienced two months (12/12 and 3/13) in which no crisis intervention restraint of any type was necessary. The Facility did not have any instances of use of Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB). The frequency of use of crisis intervention restraint had steadily decreased over the last several review periods. The Facility had done an exemplary job of ensuring restraint is used only as a last resort and has been diligent in ensuring all less restrictive measures (including just letting a behavioral outburst "run its course") to avoid use of restraint are attempted prior to a decision to restrain. The Facility is to be commended for reducing the use of crisis intervention restraint, and sustaining this reduction over time. The Facility conducted routine auditing of restraint documentation, using standardized monitoring tools.

	Sampling was not necessary because the Facility only had 11 crisis intervention restraints over the last nine months. Each instance of restraint was individually audited. Review of Positive Behavior Support Plans confirmed that restraint was only being used for crisis intervention. Restraint Monitors occasionally were involved in the application of restraint. Staff involved in the application of restraint should not act as the Restraint Monitor for the same event. As in past reviews, inconsistent restraint monitoring by nursing staff was noted and needs to be aggressively addressed. The Facility had made significant progress in complying with some requirements associated with medical restraint. Still lacking was the consistent development of strategies and programs to minimize the need for medical restraint. The Facility's restraint review practices were not detecting documentation errors, omissions, and/or inconsistencies. Additionally, the reviews were not always effective in identifying factors which needed to be addressed to minimize the need for future use of restraint with the particular individual subject to review. The Facility reported that it intended in the future to subject all crisis intervention restraints to the more rigorous review elements required under Provision C.7. This would be considered "best practice" and the Facility is to be commended for taking this initiative. 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.

#	Provision	Assessment of Status	Compliance
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	The Facility reported the following with respect to restraint use: Type of Restraint | 1/1/13 to 6/30/13 | 7/1/12 to 12/31/12 Personal restraints (physical holds) during a behavioral crisis | 6 | 7 Chemical restraints during a behavioral crisis | 0 | 1 Mechanical restraints during a behavioral crisis | 3 | 0 TOTAL restraints used in behavioral crisis | 9 | 8	Substantial Compliance

#	Provision	Assessment of Status	Compliance

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.

TOTAL individuals restrained in behavioral crisis	5	6
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	0	1
Medical/dental restraints	470*	333
TOTAL individuals restrained for medical/dental reasons	218	216

*This increase was attributed to a single Individual recently admitted to the Facility. Additionally, these data were not consistent with data reported to the Monitoring Team in Provision J.4. The Facility should consider a monthly reconciliation of identical data maintained by separate departments to ensure accurate reporting in the future.

In its last report the Monitoring Team noted that the frequency of use of crisis intervention restraint had steadily decreased over time and the infrequent use of restraint continues to be the case. The Facility is to be commended for the infrequent use of crisis intervention restraint and only using restraint when an Individual is very clearly at imminent risk of serious harm. The Facility reported no use of chemical restraint for crisis intervention since the last review and two months (12/12 and 3/13) in which no crisis intervention restraint was necessary. The Facility has over 250 Individuals with Positive Behavior Support Plans yet very limited use of restraint. The continued decrease in crisis intervention restraint suggests the Facility continues to be very proactive in providing effective supports.

In its last report the Monitoring Team noted that It can be difficult 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, and 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. Based on interview during this review it was apparent the Facility had increased staff awareness that restraint is appropriate only as a last resort and when no other mechanism exists that can remove an Individual from a situation that represents immediate and serious risk to the Individual or others. The Facility's continued decrease in the use of crisis intervention restraint was attributed, in large part, to staff being willing to let a behavioral outburst "run its course" (without restraint) so long as the situation did not escalate to placing the Individual or others at clearly apparent immediate and serious risk.

The continued infrequent use of crisis intervention restraint, along with data presented in this report, led the Monitoring Team to believe it is likely that restraint is used in a

#	Provision	Assessment of Status	Compliance
		clinically justifiable manner and not for the convenience of staff. Additionally, the Monitoring Tools used by the DSSLC to measure compliance with this part of the Settlement Agreement (SA) showed consistently high compliance with this specific requirement. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified. A sample, referred to as Sample C.1, was selected. (This was a 100% sample of the 11 crisis intervention restraints since the last review). Based on a review of the restraint records for individuals in Sample C.1 involving five individuals, none (0%) showed use of prone restraint. Based on questions with nine direct support professionals, only six (67%) were aware of the prohibition on prone restraint. These nine staff were all from residential areas where many Individuals had Positive Behavior Support Plans (PBSPs) and where restraint had occurred. The Facility had not used prone restraint and the three staff who did not articulate clearly provided responses such as "when the doctor orders it" perhaps indicating that they know not to apply any unusual restraint unless the doctor specifically orders its use. <u>Other Restraint Requirements</u> Based on document review, the Facility and State policies do state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: In 11 of the 11 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. For the 11 restraint records, a review of the descriptions of the events leading to	

#	Provision	Assessment of Status	Compliance
		behavior that resulted in restraint found that 11 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. In 11 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Facility policies do identify a list of approved restraints. Based on the review of 11 restraints, involving five Individuals, 11 (100%) were approved restraints. In 11 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. The Facility conducted auditing of restraint documentation for every instance of restraint use, using a standardized monitoring tool. This 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. At the time of the review no Individuals were the subject of physical mechanical restraint for self-injurious behavior (PMR-SIB). The Facility had one Individual subject to PMR-SIB; however, that Individual was discharged to a community placement in December, 2012. The Facility had 25 Individuals using abdominal binders as support for enteral feeding. The Monitoring Team reviewed physician orders for a 20% sample and found physician orders were for support and not for managing or controlling behavior; thus these were not considered to be medical restraint. Monitoring Team observation of some of these Individuals confirmed appropriate use of abdominal binders and that these were not used due to behavior of the individuals. Based on this review this Provision was in substantial compliance, however, additional staff training is needed to ensure all staff understands that prone restraint is a prohibited practice.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the five Individuals in Sample C.1 were reviewed. Of these, one of the individuals had a Crisis Intervention Plan that defined the use of restraint. The restraint for that individual occurred more than six months prior to this compliance visit. For the one individual who had a Crisis Intervention Plans, documentation showed that the individual was released from restraint according to the criteria set forth in the Crisis	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Intervention Plan. For four individuals who did not have Crisis Intervention Plans, four (100%) included sufficient documentation for each restraint to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review 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 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.	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. A description of Sample C.2 is provided in the Documents Reviewed section above. For Sample C.2 a review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 24 of the 24 (100%) had completed training in RES0105 Restraint Prevention and Rules within the last 12 months. • 24 of the 24 (100%) had completed PMAB training within the past 12 months. The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for DSSLC employees: 1. 99% RES0105 Restraint: Prevention and Rules for Use at MR Facilities 2. 98% RES0110 Applying Restraint Devices 3. 98% PMA0320 – PMAB Basic 4. 98% PMA0400- PMAB Restraint 5. 99% PMA0700 –PMAB Prevention 6. 99% PBS0100 – Positive Behavior Support These compliance percentages were sufficient to demonstrate substantial compliance with the training component of this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In order to evaluate staff knowledge in the area of restraint, nine Direct Care Professionals were asked a series of questions. The nine staff were selected by the Facility and included both am and pm staff, and staff from residential buildings with active Individuals, some of whom had been subject to restraint. Each response was evaluated by one member of the Monitoring Team, the Facility's CTD Director, and the Facility's senior training specialist. Consequently, for each question, responses were subjected to 27 evaluations (nine individuals times three raters). Based on responses to questions, nine direct support professionals provided satisfactory responses to the following questions as follows: • "Policies governing the use of restraint require that restraint should only be used if the Individual poses a _____and after_____." Seven of 27 responses were evaluated as satisfactory (35%); • "Describe an example of a verbal redirection technique." Twenty-six of 27 responses were evaluated as satisfactory (96%); • "Describe two restraint techniques approved for use at the Facility." Seventeen of 27 responses were evaluated as satisfactory (63%); • "What level of supervision is usually required when an Individual is in restraint?" Twenty-seven of 27 responses were evaluated as satisfactory (100%); and, • "Under what circumstances is it OK to use prone restraint?" Seventeen of 27 responses were evaluated as satisfactory (63%). The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of restraint policy. Lack of staff knowledge retained from training, at least as demonstrated by this sample of employees, could have a negative effect on future compliance with this Provision. Staff should be able to articulate that restraint is only to be used if the individual poses an immediate and serious risk of harm to him/herself or others and after a graduated range of less restrictive measures has been exhausted, state at least one example of a verbal redirection technique, two examples of approved restraint techniques, that 1:1 supervision is ordinarily required when a person is in restraint, and that there is no circumstance where prone restraint is allowable. In 11 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. As reported in Provision C.1 the Facility has done an exemplary job of ensuring restraint is used only as a last resort and has been diligent in ensuring all less restrictive measures (including just letting a behavioral outburst "run its course") to avoid use of restraint are attempted prior to a decision to restrain.	

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		Based on this review this Provision was not in substantial compliance because staff training had not resulted in demonstrated staff understanding of basic restraint policy.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 11 restraint records (Sample C.1), in 11 (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of the five Positive Behavior Support Plans for Sample C.1, in five (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. In 11 of 11 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the facility. In 10 of 11 restraint records reviewed (91%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders as documented on the form used by the facility to Individually document restraint considerations/restrictions. This was not the case for restraint of Individual # 60. In 11 of 11 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. The Facility had taken several positive steps since the last review to ensure that every Individual was assessed by the physician to determine if any medical conditions would require modification in restraint procedures in order to keep the Individual safe. This was recorded on a form, for each Individual, titled "Considerations for Implementing Restraint." This form was revised in June, 2013. In addition to checking on the presence of this form for the 11 Individuals actually restrained since the last review the Monitoring Team checked a small sample of other Individuals and found the form present in each case. The Facility is to be commended for this initiative. While the considerations form was always present the accuracy and completeness of data recorded on the form was sometimes questionable. For example in comparing data reported in the Annual Medical Assessment completed by the physician, with the considerations form the assessment reported "no risks" (for restraint use) for Individual #307. This Individuals medical condition included diagnoses of osteopenia right hip, osteoarthritis wrist, chronic right olectranon, general anxiety disorder, prehypertension, and diabetes. There was no indication recorded on the considerations form that the IDT	Noncompliance

#	Provision	Assessment of Status	Compliance
		considered musculoskeletal issues, hypertension, and diabetes when considering the use of physical or mechanical restraint. For example, exacerbation of diabetes (either very high or very low blood sugars) can cause behavior changes that led to restraint use that may have been unnecessary. In reviewing 11 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Ten (91%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • Six (55%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. Examples where this was not the case included Individuals #371 and #759; and Five of the six (83%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. This was not the case for Individual #482.Based on this review this Provision was not in compliance.	
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	Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. This training was competency-based. Based on review of restraint and training records, of the six staff at the Facility who performed the duties of a restraint monitor only three (50%) successfully completed the training within the 12 months prior to serving as a restraint monitor to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. These three staff served as a restraint monitor for eight of the 11 restraints reviewed (73%). At the time of the review all restraint monitors were current in the training. The following classes were identified as being required if someone was to act as a restraint monitor, and therefore conduct Face-to-Face Assessments. 1. ABU0100 Abuse and Neglect 2. PMA0320 PMAB Basic 3. PMA0400 PMAB4: Restraint 4. PMA0700 PMAB7: Prevention 5. CPR0100 CPR Basic 6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 7. RES0110 Applying Restraint Devices 8. PBS0100 Positive Behavior Support Based on a review of 11 restraint records (Sample C.1), a face-to-face assessment was conducted:	Noncompliance

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	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.	• In eight (73%) by an adequately trained staff member. Records that did not contain documentation of this included: Individuals #127 (11/15 at 9:31pm), #110, and #60. In the case of #110 a post restraint audit showed that the Restraint Monitor performed the duties of a restraint monitor correctly, but this was not the case for the other two; restraint checklists and FFADs were not completed. In 10 (91%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. This was not the case with restraint of Individual #214 (2:46pm). • In 10 (91%), the documentation showed that an assessment was completed of the application of the restraint. This was not the case with restraint of Individual #214 (2:46pm). • In 11 (100%), the documentation showed that an assessment was completed of the consequences of the restraint. Restraint Monitors occasionally were involved in the application of restraint. Staff involved in the application of restraint should not act as the Restraint Monitor for the same event. The purpose of having a Restraint Monitor is to ensure that an experienced staff member is monitoring the restraint with an objective point of view. To have that objectivity, the Restraint Monitor must not be engaged in the restraint. In three of the 11 (27%) this was not the case. These included: Individual #127's restraint on 11/15/12 at 8:27pm and 9:31pm and on 4/6/13 at 9:00pm. There were no instances of crisis intervention restraint where a physician had ordered an alternative monitoring schedule. Based on a review of the eight restraint records for restraints that occurred at the Facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in five of eight (63%) of the instance of restraint. Records that did not contain documentation of this included: o Individual #127: On 11/15/13 at 8:27 p.m., Individual #127 refused to allow a nursing assessment within 30 minutes of physical restraint but did allow a nursing monitoring/assessment at 10:56 p.m. On 11/15/13 at 9:31 p.m., the second sheet of the Restraint Checklist was not provided for review. Therefore, it could not be determined whether the nursing assessment was completed. o Individual #60: On 4/24/13 at 10:05 a.m., the nursing monitoring/assessment was not completed until 11:00 a.m. The physical restraint was applied at the workshop; however, there was no documentation explaining the delay of the nursing assessment.	

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		• Monitored and documented vital signs in five of eight (63%) of the instances of restraint. Records that did not contain documentation of this included: o Individual #127: On 11/15/13 at 8:27 p.m., the nurse documented that Individual #127 refused to allow vital sign monitoring/assessments every 30 minutes of the physical restraint but did allow a nursing monitoring/assessment at 10:56 p.m. On 11/15/13 at 9:31 p.m., the second sheet of the Restraint Checklist was not provided for review. Therefore, it could not be determined whether vital signs assessments were completed. o Individual #60: On 4/24/13 at 10:05 a.m., the vital signs were not completed until 11:00 a.m. The physical restraint was applied at the workshop; however, there was no documentation explaining the delay for the nursing monitoring/assessment. • Monitored and documented mental status in five of eight (63%) of the instance of restraint.. Records that did not contain documentation of this included: o Individual #127: On 11/15/13 at 8:27 p.m., the nurse documented that Individual #127 refused to allow vital sign assessments every 30 minutes of the physical restraint but did allow a nursing monitoring/assessment at 10:56 p.m. On 11/15/13 at 9:31 p.m., the second sheet of the Restraint Checklist was not provided for review. Therefore, it could not be determined whether mental status assessments were completed. o Individual #60: On 4/24/13 at 10:05 a.m., the vital signs were not completed until 11:00 a.m. The physical restraint was applied at the workshop; however, there was no documentation explaining the delay of the nursing monitoring/assessment. • If the individual's behavior made it difficult to conduct this monitoring, the licensed health care professional needs to document what he/she was able to do. • There should be documentation from nursing describing the individual that objectively indicates that he or she appeared medically stable, such as comments regarding gait, behavior, and mental status. Merely documenting "refused" is not acceptable. Respirations should be obtained; they do not require an individual's cooperation and the nurse should be able to determine whether the individual was having any respiratory distress. In addition, the mental status section should include specific behaviors that support the current mental status description. "Alert and oriented" or "back to baseline" are inadequate. Based on documentation provided by the Facility, three restraints had occurred off the grounds of the Facility in the last six months. A licensed health care professional: • Conducted monitoring within 30 minutes of the individual's return to the Facility	

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		in two out of three (67%). Records that did not contain documentation of this included: o Individual #127: On 4/6/13 at 9:02 p.m., Individual #127's physical restraint was applied off campus. At 2100 (9:00 p.m.) the Restraint Checklist documented that the nurse was notified of his return to campus but the nurse did not assess Individual #127 until 11:15 p.m. (2315). There was no documentation explaining the reason for the delay in completing the monitoring/assessment. • Monitored and documented vital signs in two out of three (67%). Records that did not contain documentation of this included: o Individual #127: On 4/6/13 at 9:02 p.m., Individual #127's physical restraint was applied off campus. At 2100 (9:00 p.m.) the Restraint Checklist documented that the nurse was notified of his return to campus but the nurse did not assess Individual #127's vital signs until 11:15 p.m. (2315). • Monitored and documented mental status in two out of three (67%). Records that did not contain documentation of this included: o Individual #127: On 4/6/13 at 9:02 p.m., Individual #127's physical restraint was applied off campus. At 2100 (9:00 p.m.) the Restraint Checklist documented that the nurse was notified of his return to campus but the nurse did not assess Individual #127's mental status until 11:15 p.m. (2315). Sample C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 11% of the individuals for whom medical restraint was used. (Sample C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In 11 out of 11 (100%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • In 11 out of 11 (100%), the physician specified the type of monitoring required if it was different than the facility policy. • In 11 out of 11 of the medical restraints (100%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. In a different sample for Section Q of this report comprised of ten individuals who had dental pre-treatment sedation, the Monitoring Team did not find evidence to support that nursing staff or DSPs consistently monitored the Individuals through the 24 hours following the procedures. • In seven out of ten cases (70%), the nurse documented post sedation monitoring	

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		on the procedure and recovery monitoring form, per protocol. Post sedation monitoring forms were not provided for two out of ten cases. • The medical restraint checklist was fully completed by the nurse in zero out of ten cases (0%). In only two cases was DSP instruction documented, and in no cases was there post sedation monitoring information completed. • Per review of the provided IPNs, there was no evidence to support that nursing staff or DSPs monitored the individual through 24 hours following the procedure, although there were occasional nursing IPNs documenting such monitoring. Based on this review this Provision was not in substantial compliance.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample C.1) of 11 Restraint Checklists for individuals subject to crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: • In 11 (100%), continuous one-to-one supervision was provided; • In 11 (100%), the date and time restraint was begun; • In 11 (100%), the location of the restraint; • In one (9%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. This was the case with Individual #10. Note: the Restraint Checklist in the section labeled Description of Behaviors Prior to Restraint includes the prompt, "Describe the individual's environment, actions, and interactions with others <u>in the time before you began taking steps to avoid the use of restraint</u>" (emphasis added)." In 10 restraints (91%) information addressing this was either overly general or nonexistent. • In one (9%), the actions taken by staff prior to the use of restraint to permit adequate review per Provision C.8. Refer to above paragraph. • In 11 (100%), the specific reasons for the use of the restraint; • In 11 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In 11 (100%), the names of staff involved in the restraint episode; • In 10 (91%) observations of the individual and actions taken by staff while the individual was in restraint, including at release. For restraint of Individual #127 (11/15 at 9: 31) the Facility did not provide a complete Restraint Checklist (two pages were missing). This was pointed out on the first day of the review. All 11 restraints were of short duration, the longest being 15 minutes (arm splints). • In 11 (100%), the level of supervision provided during the restraint episode; • In 10 (91%), the date and time the individual was released from restraint. For restraint of Individual #127 (11/15 at 9: 31) the Facility did not provide a	Noncompliance

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		complete Restraint Checklist.; and • In nine (82%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. This was not the case for restraints of Individual #127 (2x). In a sample of 11 records (Sample C.1), restraint debriefing forms had been completed for 11 (100%); however, data was not always consistent with data recorded on the Restraint Checklist or elsewhere. For example, for restraint of Individual #127 (11/15 at 8:27pm) the nurse made no entry on the checklist with respect to whether or not the Individual was injured. The debriefing reports "no injury" in section 2.4 but "yes an injury report was started" in section 3.7. This was also the case for Individual #127 (11/15 at 9:31pm). The checklist and debriefing for Individual #110 reported no injury but the Unit review meeting documented an injury related to the restraint event. Because of these inconsistent data the compliance rate is eight of 11 (73%). A sample of 11 individuals subject to medical restraint was reviewed (Sample C.3), and in 11 (100%), there was evidence that the monitoring had been completed as required by the physician's order. No Individuals were the subject of crisis intervention chemical restraint since the last review. Based on this review the Facility was not in compliance with this provision.	
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:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to Facility documentation, during the six-month period prior to the onsite review, one individual was placed in restraint more than three times in any rolling 30-day period. This single individual (#127) comprised the sample for review to determine if the requirements of the Settlement Agreement were met. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Records for Individual #127 included documentation of an ISPA following the single episode of the individual having more than three restraints in a rolling 30 days. Although the individual did have four restraint applications in a rolling 30-day period, the final two	Substantial Compliance

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		applications occurred on the same day within a period of several minutes. For the individual reviewed, the individual's IDT (as reflected in the ISPA) discussed the individual's adaptive skills and biological, medical, and psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables influencing the individual's behavior. The assessments provided to the IDT as part of the review were very thorough as evidenced by the following examples. • The assessment of adaptive skill factors encompassed a broad set of skills, and presented information in terms of weaknesses, strengths, and those factors that could have contributed to the incidents requiring restraint. • The narrative concerning biological and medical issues included a review of psychiatric and medical diagnoses, current medical treatments, and potential ways in which these factors could have contributed to the challenging behavior. • The material provided for review by the IDT discussed at length the psychosocial factors that were likely to have contributed to the behavior requiring restraint. This included a review of the individual's birthday, which was celebrated early by his family, as well as his twin sister having the opportunity to move home. The displays of the challenging behaviors were presented in chronological order and involved considerable detail about precursors, setting events, antecedents, and consequences for the behavior. In the single case reviewed (100%), one or more of these factors were hypothesized to affect the behaviors that provoke restraints. In the single case reviewed (100%), there was evidence of an action plan or discussion/recommendations, identified in the ISPA, for modifying them to prevent the future probability of restraint.	
	(b) review possibly contributing environmental conditions;	Records for Individual #127 included documentation of an ISPA following the single episode of the individual having more than three restraints in a rolling 30 days. Although the individual did have four restraint applications in a rolling 30-day period, the final two applications occurred on the same day within a period of several minutes. For the individual reviewed, the individual's IDT (as reflected in the ISPA) had discussed the possibly contributing environmental conditions. This included a consideration of interactions with a housemate and a nurse that may have served as triggers following prolonged rumination about the psychosocial variables. The single case reviewed (100%) included documentation of review of possibly contributing environmental conditions. For the individual in the sample, IDT review documentation reflected a review of the most recent behavior assessments addressing the antecedents and consequences related to the behavior resulting in restraint.	Substantial Compliance

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	(c) review or perform structural assessments of the behavior provoking restraints;	Records for Individual #127 included documentation of an ISPA following the single episode of the individual having more than three restraints in a rolling 30 days. Although the individual did have four restraint applications in a rolling 30-day period, the final two applications occurred on the same day within a period of several minutes. For the individual reviewed, the individual's IDT (as reflected in the ISPA) had discussed potential environmental antecedents to the behaviors that preceded restraint, For the single case reviewed (100%), IDT review documentation reflected a review of the most recent behavior assessments addressing characteristics of the external environment (i.e. availability of choice, population density, etc.) and internal environment (i.e. mental illness, neurological disorders, etc.) related to displays of behavior resulting in restraint. These assessments were thorough and involved data from both direct observations and reports from staff.	Substantial Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Records for Individual #127 included documentation of an ISPA following the single episode of the individual having more than three restraints in a rolling 30 days. Although the individual did have four restraint applications in a rolling 30-day period, the final two applications occurred on the same day within a period of several minutes. For the individual reviewed, the individual's IDT (as reflected in the ISPA) had discussed the variable or variables that potentially are maintaining the behavior provoking restraints. The material reviewed reflected close consideration of environmentally maintained behaviors and symptoms of mental illness, as well as the manner in which the behavioral and the psychiatric factors might have contributed to the challenging behavior. For the single case reviewed (100%), IDT review documentation reflected a review of the most recent behavior assessments addressing the function of the behavior (i.e. escape from attention, obtaining tangibles, etc.) resulting in restraint.	Substantial Compliance
	(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	Records for Individual #127 (100%) reflected a PBSP current at the time of each restraint application. The reviewed PBSP (100%) had operationally defined target behaviors. The reviewed PBSP (100%) contained functional replacement behaviors. The reviewed PBSP (100%) specified, as appropriate, the use of other programs to	Substantial Compliance

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	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;	reduce or eliminate the use of restraint. This included guidance on how to monitor the individual's behavior during times of elevated stress or mental illness. In addition, due to the precipitating factors involving family and celebrations, it was recommended that steps be taken to ensure the individual had a variety of alternate activities available at the Facility during such times. The reviewed PBSP (100%) contained interventions to weaken or reduce the behaviors that provoked restraint and that were clear, precise and based on a functional assessment. The Crisis Intervention Plan delineated the type of restraint authorized. The Crisis Intervention Plan specified the maximum duration of restraint authorized. The Crisis Intervention Plan specified the designated approved restraint situation. The Crisis Intervention Plan specified the criteria for terminating the use of the 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	Records for Individual #127 did not reflect the presence of treatment integrity data from the period surrounding the applications of restraint for the individual having more than three restraints in a rolling 30 days. Records for Individual #127 did not reflect the treatment plan was implemented with at least 80% treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Records for Individual #127 included documentation of a review of the PBSP in the ISPA following more than three restraints in a rolling 30 days. For this individual, a revision to the PBSP was underway at the time of the restraint applications. The revised PBSP was implemented eight days after the final restraint application.	Substantial Compliance
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	The Facility had an organized process for restraint review. This was described in the Facility restraint policy, which closely mirrors the State restraint policy. Review starts with a FFAD done by a restraint monitor immediately after the restraint episode. The restraint episode is to be reviewed in the unit morning meeting the next business day with whatever information had been available by the time of the meeting. It is to be reviewed that same day by the IMRT, often based on verbal reports from staff. The restraint episode is to be kept on the agenda of both meetings until the restraint	Noncompliance

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	restraint, other than medical restraint. ISPs shall be revised, as appropriate.	checklist, FFAD, and debriefing have been completed and each review level has the necessary information to conduct a final review. Additionally, the IDT would be expected to meet shortly after the restraint episode to assess any needed interventions or changes in the Individual's program plan, including the Positive Behavior Support Plan and/or Crisis Intervention Plan, where applicable. Documentation provided to the Monitoring Team to validate these steps was not always apparent. The Monitoring Team could not validate that the IMRT, at the time of its review, had sufficient behavioral and other observational data, to accurately determine "the circumstances under which restraint was used". The Facility reported that it intended in the future to subject all crisis intervention restraints to the more rigorous review elements required under Provision C.7. This would be considered "best practice" and the Facility is to be commended for taking this initiative. As reported in Provisions C.4, C.5, and C.6 the Monitoring Team identified errors, omissions, and/or inconsistencies on and/or between the Restraint Checklist and the Debriefing form that should have been identified and corrected as part of the restraint review by the Restraint Monitor or by other restraint review mechanisms in place at the Facility. Documentation related to Facility review of 11 incidents of crisis intervention restraint was reviewed by the Monitoring Team. This included the Unit Review Team meeting minutes, IMRT meeting minutes, ISP addenda, and debriefing documentation. This documentation showed that: • In seven (64%), the review by the Unit IDT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist and review of unit review meeting minutes. This was not the case with restraint of Individual #127 (11/15, 4/6, 4/7, and 4/9). While the Unit IDT minutes reflect the meeting occurred this was not validated on the Restraint Checklist. • In nine (82%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by date entry on the Restraint Checklist and review of IMRT minutes. This was not the case with restraint of Individual #214 (2x). • In 11 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • In four (36%), 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	

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		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. This was not the case with Individuals #127 (4/6, 4/7, and 4/9 2x), #214 (2x), and #60. This was attributable to the lack of substantive review information reported in either the Unit review or IMRT minutes. Little information was provided in either review that addressed 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 in preventing restraint. • In 11 (100%), referrals were made to the team, as appropriate; and • Of the 11 referred to the team, in nine (82%) appropriate changes were made to the individuals' ISPs and/or PBSPs. Those that did not were Individual #214 (2x). No change had been made, and there was no documentation that the IDT gave consideration to whether changes were needed. Restraint data was reviewed monthly at a Facility Monthly Trends Meeting. Restraint practices, including those effecting specific Individuals, are part of the review and discussion at these meetings. Membership of this group included Residential Unit Directors, Behavioral Services staff, and other key administrative and clinical leadership at the Facility. The Quality Assurance/Quality Improvement Council (QA/QI) also reviewed restraint procedures used across the Facility quarterly. 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. Based on this review the Facility is not in compliance with this provision. This represents regression in the restraint review process as the Facility was in substantial compliance at the last review. The Facility reviews of restraint by both the unit review teams and the IMRT did not always occur within three business days as required by the SA.	

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 3. Settlement Agreement (SA) Section D Presentation Book (undated) 4. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 12/3/12 5. DADS Policy 02.3 Incident Management 11/20/12 6. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 2/1/13 7. DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 2/1/13, 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 8. Minutes of DSSLC's quarterly meeting with Department of Family and Protective Services (DFPS) 11/20/12 and 5/8/13 9. Training Curriculum for Course ABU0100 Abuse and Neglect 4/25/12 10. Sample of Employee Training Records – Sample C.2 11. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 6/1/13 12. Sample of Acknowledgment of Responsibility for Reporting Abuse, Neglect, and Exploitation employee forms. 13. DSSLC Annual Employee Registry Check and Fingerprint Criminal History Check 10/12/12 14. DSSLC report on volunteer background checks 9/13/12 15. "You Have the Right" poster 7/17/09 16. "Report Abuse or Neglect" poster 4/05 17. "Prevent Abuse & Neglect Poster" (undated) 18. Current mailer to LARs regarding abuse, neglect, and exploitation 19. Incident Management Review Team Meeting minutes for 3/18, 3/25,4/1, 4/8. 4/15, 4/22, 4/29, 5/6, 5/13, 5/21, and 6/3/13 20. Allegation, Injury, and UIR Trend Report 6/13 21. Individual Training Records for Facility and Department of Family and Protective Services (DFPS) Investigators 22. DFPS case log 10/1/12 to 6/19/13 23. OIG case log 10/1/12 to 6/19/13 24. Serious Incident (other than ANE) log 10/1/12 to 6/18/13 25. Serious Injury log 10/1/12 to 6/18/13 26. Witnessed Injury log 10/1/12 to 7/21/13 27. List of the most frequently injured Individuals 10/1/12 to 6/18/13 28. Discovered Injury log 10/1/12 to 7/21/13 29. Peer caused injury log 10/1/12 to 6/18/13

	30. Independent Ombudsman Survey Report from review 9/11 to 9/14/12 31. Log of allegations reported by Individuals living at the Facility since the last review 6/20/13 32. Sample D.1: included a sample of DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports for DFPS cases 63462996, 63466707, 42704888, 42712348, 63536007, 63530425, 42743752, 42744552, 42744449, 42749188, 6361475, 42752511, 42754117, and 42753935. This sample was selected from the document the Facility submitted listing the allegations/investigations completed over the last six months. The sample was 20% of reported investigations initiated and completed over the last six months and represented investigations that resulted in confirmed, unconfirmed, inconclusive, and administrative referral findings. 33. Sample D.2: included a sample of Facility-only investigation reports selected from the document the Facility provided listing investigations completed over the last six months UIRs 122, 129, 145, 170, 184, 185, 194, 195, and 196. The sample was 20% of reported investigations initiated and completed since the last visit and included serious injuries and other serious incidents. 34. Sample C.3: the sample of Individual Support Plans (ISPs) reviewed. These were the ISPs that were part of Sample C.1 (11 crisis intervention restraints). 35. List of employees who failed to report or were late in reporting since the last review 36. Under Reporting Audit reports January to June, 2013 37. Rights Poster Audit reports July, 2012 38. Self-Advocacy meeting minutes since the last review (9) 39. QA/QI committee meeting minutes: January to June, 2013 **People Interviewed:** 1. Nancy Condon, Facility Director 2. Deb Salsman, Director of Incident Management 3. Jeron Dotson, Incident Management Coordinator 4. Elaine Davis, CTD Director 5. Scot Moore, Senior Training Specialist 6. Nine Direct Care Professionals (DCP's) from Timberhill and Garden Ridge residential units **Meetings Attended/Observations:** 1. Incident Management Team (IMRT) 7/25/13 2. Unit Review meeting 7/24/13 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 7/24/13 4. Critical Incident Team (7/25/13)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D. 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. For Section D, in conducting its self-assessment, the Facility: • Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff:

	o The monitoring/audit tools the Facility used to conduct its self-assessment included the Section D DADS Monitoring Tool o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Sample sizes were generally 20% of the N. The sample sizes were adequate to consider them representative samples. o The monitoring/audit tools did have adequate written instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Incident Management Coordinator and IMC Investigators. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established to validate the monitoring findings for Section D. • The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on specific, measurable indicators and used these data in initiating corrective actions o Measured the quality as well as presence of items. • The Facility rated itself as being in compliance with 19 of the 22 Provisions of Section D. The Monitoring Team found the Facility to be in compliance with 15 Provisions. The Provisions where the Facility self-assessed compliance and the Monitoring Team did not included:, 1) Provision D.3.e (not all investigations were completed within required timeframes), 2) Provision D.3.g (not all investigations are thorough and complete), 3) Provision D.3.i (disciplinary and programmatic actions following an investigation are not monitored closely by the Facility Incident Management Review Team – IMRT), and 4) Provision D.4 (action plans developed subsequent to trend reviews are not implemented fully and/or timely). The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve continued compliance. • Actions were reported as completed or in progress. • The Facility data identified areas of needed improvement. The Facility's defined processes for auditing the administrative requirements associated with Section D compliance appeared to be sufficient to conduct future self-assessments • The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. There were five Provisions the Facility self-assessed as in compliance that were

	not. The Facility Action Plan needs to address these five provisions. The Facility highlighted seven actions for the Monitoring Team at the review entrance meeting. These included: 1) improved review of reports, 2) enhanced discovered injury investigations, 3) new experienced investigator on board, 4) more trained investigators combined with lead has improved investigations, 5) trends analysis reports and minutes combined for easier tracking of actions and results, 6) consequences for late reporting heightened, and 7) continued zero tolerance of abuse, neglect, or exploitation.
	Summary of Monitor's Assessment: The Facility rated itself as being in compliance with 19 of the 22 Provisions of Section D. The Monitoring Team found the Facility to be in compliance with 15 Provisions. The Provisions where the Facility self-assessed compliance and the Monitoring Team did not included: 1) Provision D.3.c (not all allegations of physical abuse were reported to law enforcement), 2) Provision D.3.e (not all investigations were completed within required timeframes), 3) Provision D.3.g (not all investigations are thorough and complete), 4) Provision D.3.i (disciplinary and programmatic actions following an investigation are not monitored closely by the Facility Incident Management Review Team – IMRT), and 5) Provision D.4 (action plans developed subsequent to trend reviews are not implemented fully and/or timely). The Facility has most of the administrative systems in place to achieve compliance with Section D but needs to pay more attention to detail, identifying problems and mistakes, and taking aggressive actions to correct them and prevent recurrence. This was evident when comparing Provisions the Facility self-assessed as in compliance but the Monitoring Team did not find compliance. While late reporting of allegations of abuse, neglect, and serious incidents had improved compared to that noted in the last report, it is still occurs too often. On a positive side the Facility now self-identifies most of these. The Monitoring Team found only one instance of a late report which was not self-identified. The number of confirmed findings of abuse and neglect had decreased significantly from 20 to eight, comparing the 12 month period ending June 2013 with the period ending June 2012. The Facility had initiated three noteworthy actions: 1) taking additional steps to protect the integrity of testimonial evidence by implementing a "Testimonial Evidence Acknowledgment Form", 2) implementing a system of regular phone calls to LARs/guardians to engage in conversation about abuse and neglect and reporting, and 3) putting screen saver slides on computers used by Direct Care Professionals (DCPs) re-enforcing abuse and neglect reporting. The thoroughness and completeness of Facility review of facility investigations of UIRs had improved from that observed at the last review but was still not sufficient to ensure content of investigations was thorough and complete and that the report is accurate and complete.

	The Facility process for review of DFPS investigation reports had improved compared to what was observed at the last review. The Facility experienced continued improvement 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 thoroughness and completeness of DFPS investigations remains an occasional problem. In one case with an inconclusive finding relevant witnesses weren't interviewed. Investigations of serious discovered injuries had improved but too often conclude a "determined cause" with little or no evidence to support the conclusion. Often, 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. The Facility had engaged in improved practices in its review activity of non-serious discovered injuries. 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. The DFPS Supervisor who oversees Facility investigations regularly participates in New Employee Orientation at the Facility. Reporting procedures were prominently displayed throughout the Facility and are printed on the back side of employee identification badges. In every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no direct contact status. The audit procedure required by DADS to detect under-reporting of significant incidents had been in place at the Facility and was being administered correctly. Improvement is needed in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs). Compliance with required background checks was confirmed.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that	The Facility's policies and procedures CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) did: • Include a commitment that abuse and neglect of individuals will not be tolerated,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	• Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. 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. 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. 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. 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 deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with	Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed and appropriate actions taken. The Facility's progress in analyzing data	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement. According to data the Facility provided to the Monitoring Team, the numbers of abuse/neglect/exploitation allegations for the past two twelve-month periods were:	

	7/1/12 to 6/30/13	7/1/11 to 6/30/12
Total abuse allegations	171	196
Physical	118	154
Verbal/Emotional	53	42
Abuse substantiated	8	20
Physical	6	17
Verbal/Emotional	2	3
Abuse inconclusive	16	12
Physical	10	9
Verbal/Emotional	6	3
Total neglect allegations	49	143
Neglect substantiated	7	11
Neglect inconclusive	0	1
Total exploitation allegations	6	10
Exploitation substantiated	3	0
Exploitation inconclusive	0	0

According to Facility data provided to the Monitoring Team, the numbers of Unusual Incidents investigated over the past two twelve-month periods included:

	7/1/12 to 6/30/13	7/1/11 to 6/30/12
Deaths	8	18
Serious Injuries	49	40
Sexual Incidents	0	8
Suicide Threat (credible)	0	0
Unauthorized Departure	6	4
Choking	14	12
Other	18	7

Based on the Monitoring Teams' review of DADS revised policies, including Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies

#	Provision	Assessment of Status	Compliance
		were consistent with the Settlement Agreement requirements. According to Facility policy CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) staff were required to report abuse, neglect, and exploitation within one hour by calling the DFPS 800 number and reporting to the Facility Director/designee. This was consistent with the Settlement Agreement requirements. With regard to unusual/serious incidents, the Facility policy entitled CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to call the Facility Director/designee. This policy was consistent with the Settlement Agreement requirements. In order to evaluate staff knowledge in the area of abuse and neglect nine Direct Care Professionals were asked a series of questions. The nine staff were selected by the Facility and included both am and pm staff, and staff from two residential units. Each response was evaluated by one member of the Monitoring Team, the Facility's CTD Director, and the Facility's Senior Training Specialist. Consequently, for each question responses were subjected to 27 evaluations (nine staff times three raters). Based on responses to questions, nine direct support professionals provided satisfactory responses to the following questions as noted: "Describe the reporting procedure and timeframe when abuse/neglect is suspected." Twelve of 27 responses were evaluated as satisfactory (44%). "Describe the reporting procedure and timeframe for other serious incidents." Twelve of 27 responses were evaluated as satisfactory (44%). The above data suggests staff is not retaining information learned in formal training classes and may contribute to the problem the Facility identified in its self-assessment (and confirmed by the Monitoring Team) of late reporting. Lack of staff knowledge retained from training, at least as demonstrated by this sample of employees, could have a negative effect on future compliance with this provision. The Monitoring Team did identify one unique strategy to reinforce key provisions of abuse and serious incident policy. The Facility had 92 computer kiosks in residential and program areas that are used primarily by Direct Care Professionals (DCPs). When the computer is not in use, a rotating set of 14 screen saver slides is displayed. Seven of these slides are different reminders about abuse, neglect, and serious incident reporting. Many	

#	Provision	Assessment of Status	Compliance
		of these kiosks are in open areas where staff walking by would likely view the screen (each slide is in color and is eye-catching). Based on a review of the 14 investigation reports included in Sample D.1: ▪ For five, the time of the incident was unknown so it could not be determined if it was reported in accordance with policy. ▪ Of the remaining nine, seven (78%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. Those that did not included investigations 42703165 and 42723341. ▪ Of the remaining nine, seven (78%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party required by DADS/Facility policy. Those that did not included investigations 42703165 and 42723341. ▪ For the two allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, evidence provided to the Monitoring Team confirmed recommendations for corrective action occurred in both cases. Based on a review of nine investigation reports included in Sample D.2: ▪ Nine (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. ▪ Nine (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. The Facility did have a standardized reporting format. Based on a review of 23 investigation reports included in Samples D.1 and D.2, 23 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Based on this review this Provision is not in substantial compliance. Late reporting remains a problem at the Facility and needs to be aggressively addressed**.**	
	(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	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) the Facility is required to immediately remove any alleged perpetrator of abuse or neglect from contact with Individuals, placing the affected staff in NDC (no direct contact) status. Additionally, the Facility is to take immediate steps with the affected Individuals such as a nursing assessment and an emotional assessment. Based on a review of 14 investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no direct contact (NDC) status.	Substantial Compliance

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	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.	Based on a review of 14 investigation files included in Sample D.1 14 (100%) showed that no staff that had been removed from direct contact were subsequently reinstated prior to the completion of the investigation. Based on a review of 14 investigation files, it was documented that adequate additional action was taken to protect individuals in 13 cases (93%). Actions included, for example, medical assessment/care, increased home and/or Individual supervision, and emotional assessment of the alleged victim(s). This was not the case with UIR 144. 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. To remain in substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: 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.. Based on this review the Monitoring Team determined this Provision was in complianc;e 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.	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management), required all staff to complete the DADS competency based class on Abuse, Neglect, and Exploitation (ABU0100). This was consistent with the requirements of the Settlement Agreement. A review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: ▪ In relation to the requirement that training is competency-based, the Monitoring Team reviewed the curriculum and determined the training was competency based. ▪ The training curriculum did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 24 staff records (Sample C.2), showed that 24 (100%) of these staff had completed competency-based training on abuse and neglect as part of New Employee	Substantial Compliance

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		Orientation and therefore prior to working directly with individuals. Review of DADS computer reports displaying the percentage of completion for training classes showed that 99% were current in completing A/N training. In order to evaluate staff knowledge in the area of abuse and neglect nine Direct Care Professionals were asked a series of questions. The nine staff were selected by the Facility and included both am and pm staff, and staff from two residential units. Each response was evaluated by one member of the Monitoring Team, the Facility's CTD Director, and the Facility's Senior Training Specialist. Consequently, for each question responses were subjected to 27 evaluations. Based on responses to questions, nine direct support professionals provided satisfactory responses to the following questions as follows: "Describe two signs or symptoms of abuse." 21 of 27 responses were evaluated as satisfactory (78%). "Describe two signs or symptoms of neglect." 21 of 27 responses were evaluated as satisfactory (78%). "Describe two other types of serious incidents (other than abuse/neglect) that must be reported." 12 of 27 responses were evaluated as satisfactory (44%). The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of abuse and serious incident reporting policy**.** Lack of staff knowledge retained from training, at least as demonstrated by this sample of employees, could have a negative effect on future compliance with this provision. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(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	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management), staff is notified of abuse/neglect reporting responsibilities and must sign an acknowledgment form. This is Form 1020. Copies were requested of the forms for staff hired during the two full months prior to the on-site review. Based on a review of those forms, 100% of staff hired during this time period had signed the acknowledgement form. A sample of 24 staff (Sample C.2) was randomly selected to determine if annual	Substantial Compliance

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	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.	acknowledgements had been signed. Of the 24, 24 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff that had been identified as having failed to report abuse and/or neglect in accordance with Facility policy (within one hour) This generated a list of 13 staff. This was identified by the Facility in its review of UIRs. Personnel actions related to these failures were reviewed and in all cases administrative/disciplinary action appropriate to the circumstances was taken. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(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.	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management), IDTs were to provide LARs with written communication on abuse/neglect identification and the reporting process. Additionally, this topic is to be a regular point of discussion at each Individual's ISP meeting. A review was conducted of the materials to be used educate individuals. Materials included necessary information and were easy to understand and available in English and Spanish language versions. A review was conducted of the materials to be used to educate legally authorized representatives (LARs) or others significantly involved in the individual's life. Materials were easy to understand and available in English and Spanish language versions. Based on a review of five Individuals' ISPs (Sample C.1), five (100%) Individuals, or their LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. It was evident to the Monitoring Team that the ISP process in place at the Facility regularly and routinely covered the topic of abuse/neglect identification and reporting. Self-advocate meetings occurred monthly at the Facility. In reviewing minutes the Monitoring Team found agenda topics relevant to this provision was presented in five of nine (55%) meetings, which was satisfactory. Additional validation of compliance with this Provision was provided in a survey completed by the Independent Ombudsman which included a four day site review. This survey occurs annually and the survey report was presented to the Facility QA/QI Council. This survey included an interview with 49 Individuals. From this survey it was reported: • 60% of respondents reported they had been informed of their rights and could name some of their rights.	Substantial Compliance

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		• 80% reported they know what to do if they have a rights concern. • 80% reported they are comfortable speaking up for themselves. The survey included a family member component. Family member respondents reported: • 100% had been notified of the Individuals rights. • 67% know how to file a complaint. The Facility had engaged in further action to strengthen compliance with this Provision by regularly calling LARs/guardians to engage in conversation about abuse/neglect and reporting. These calls are documented on a log which reported over 420 phone calls to LAR/guardians since this process was put in place in March, 2012. Forty-eight allegations of abuse or neglect were reported by Individuals, further evidence that they are aware of their rights and exercise them. Based on this review the Monitoring Team determined this Provision was in substantial compliance.	
	(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.	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management), postings directed at compliance with this requirement are to be maintained at all times. A review was completed of the posting the Facility used. It did include a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. Observations by the Monitoring Team of three living units on campus showed that three (100%) had postings of individuals' rights in an area to which individuals regularly had access. The Facility had on ongoing surveillance process that ensures the presence of posters is maintained and the Monitoring Team reviewed documentation reports to validate this surveillance. As reported in Provision D.2.e, a review completed by the Independent Ombudsman, which included an interview with 49 Individuals, reported: • 60% of respondents reported they had been informed of their rights and could name some of their rights. • 80% reported they know what to do if they have a rights concern.	Substantial Compliance

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		• 80% reported they are comfortable speaking up for themselves. As reported in Provision D.2.a, the Facility had 92 computer kiosks in residential and program areas that are used primarily by Direct Care Professionals (DCPs). Many of these kiosks are in areas frequented by Individuals living at the Facility. When the computer is not in use, a rotating set of 14 screen saver slides is displayed. Seven of these slides are different reminders about abuse, neglect, and serious incident reporting. Many of these kiosks are in open areas where Individuals walking by would likely view the screen (each slide is in color and is eye-catching). Based on this review the Monitoring Team determined this Provision was in compliance.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) allegations of abuse/neglect are to be reported, as appropriate, to law enforcement. Based on a review of 14 allegation investigations completed by DFPS (Sample D.1), in eight for which a referral to law enforcement was necessary/appropriate, the Facility had made referrals in seven of eight (88%). Based on a review of nine investigations completed by the Facility (Sample D.2), in none was a referral to law enforcement necessary/appropriate. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(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	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management), retaliation against reporters of abuse/neglect is prohibited and not tolerated. Based on interviews with the Facility Director, Director of Incident Management, and the Incident Management Coordinator, these requirements are included in training curriculum and reinforced using postings throughout the Facility. Each stated emphatically that retaliation is not tolerated and when alleged or detected was formally investigated. Nine Direct Care Professionals were asked two questions regarding retaliation. Their responses were: If you reported abuse or neglect would you worry about being retaliated against by a	Substantial Compliance

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	manner.	coworker or supervisor? All nine (100%) reported they would not worry about being retaliated against. If retaliation did happen, or was suspected, should it be reported? All nine answered yes. If so, to whom? All nine answered satisfactorily indicating they would report the alleged retaliation to an investigator, campus administrator, or Facility Director. As noted in Provision D.2.e in response to a survey conducted by the Independent Ombudsman, 80% of 49 Individuals interviewed reported they were comfortable in speaking up for themselves. This suggests that they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample D.1 and Sample D.2), there were not concerns noted related to potential retaliation. Based on this review this Provision was in substantial compliance.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Facility policy CMGMT-01B (Incident Management) did not define sufficient procedures to audit whether significant injuries are reported for investigation. The Facility reported it was following a DADS issued procedure for these audits. This procedure should be incorporated in to Facility policy. The DADS procedure referenced above establishes a general framework for the review and investigation of injuries. This procedure reports the following as its purpose: 1. A process to conduct audits of the resident's records to detect incidents which may have resulted in an injury and generate a Client Injury Report (CIR). 2. The proper coding of injuries to residents 3. Decreasing injuries of known or unknown source or origin 4. Ensuring residents remain free from abuse, neglect, or exploitation 5. Compliance with significant injury audit requirements D2i of the Settlement Agreement. The procedure calls for a six-month review of a 20% sample of Individuals living at the Facility. The required review looks at, at a minimum, Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to review and identify incidents that may have resulted in completing an injury report and a UIR. The audit also is to determine if the injury was coded and investigated (serious injuries and injuries of unknown source) per SSLC Incident Management Policy and Injury Reporting Procedure. This procedure states that the review process will consider the injury as suspicious, but does not specifically require that the Facility review, Individuals who had multiple minor injury issues that may represent a pattern or trend that might merit	Substantial Compliance

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		further investigation, either because of the type or body location of injury, location or shift that injuries occur on, a preponderance of discovered injuries, and any other variables that might merit examination and could be potentially useful in reducing the number of injuries incurred by that Individual. Audits conducted pursuant to this Provision should include at a minimum procedures that include: ▪ Injuries to be identified should include, but not be limited to those injuries defined in DADS policy as "serious injuries" as well as non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries (e.g., several injuries at the same time or over time, patterns of types of injuries to specific individuals or in a particular living unit, locations of injuries). Such injuries might be of "known" or "unknown source." For example, "causes" might have been identified, but a type of injury or pattern of injuries might still require investigation. Procedures should identify the process or processes for audits, who will do the audits, who will be audited (and, if a sample, how the sample is to be selected), and to whom reports are made. ▪ Reviews should include a sample of Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to identify any incidents that should have resulted in completing a Client Injury Report, and a comparison to determine if incident reports were filed. ▪ Reviews also should be completed of incident data to identify trends or patterns of incidents for specific individuals or residences, as well as identification of peer-to-peer aggression resulting in injuries that requires investigation. The audit procedure required by DADS had been in place at the Facility and was being administered correctly. The Facility had conducted audits at least semi-annually, during the preceding 13 months; however, data provided to the Monitoring Team to establish compliance with this Provision did not include trends or patterns of incidents for specific individuals or residences, or peer-to-peer aggression resulting in injuries. From 10/1/12 to 7/19/13 the Facility had reported 1631 discovered injuries, 684 of which occurred in bedrooms, 348 of which occurred in bathing areas, and 305 of which occurred in living rooms. Ten Individuals had been injured more than 50 times in the nine months prior to this review. Five Individuals had caused more than 30 injuries (peer-to-peer aggression) in the nine months prior to this review. The Facility databases were extensive and can produce reports organized around multiple variables which could help in identifying trends or patterns requiring additional investigation. Data review and analysis could determine if a significant number of these injuries occur when a certain staff person is on duty, or they occur at a certain location, or a certain time window, or any other variable determined to be potentially significant. This data analysis (i.e. the semi-annual audit referenced in the SA) could determine that a formal investigation should be initiated.	

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		The audits conducted of sampled Individuals were sufficient to determine whether significant resident injuries had been reported for investigation. The audits included 45 discovered injuries and determined five (11%) were not adequately documented and/or reported. In each case the Facility took appropriate remedial actions. Additionally, the Facility had engaged in improved practices in its review activity of non-serious discovered injuries to ensure they were not significant and therefore merited official investigation via the UIR process, or reported to DFPS because of a suspicion of abuse or neglect. The accuracy and completeness of the Facility's review of non-serious injuries had improved significantly from that observed in previous reviews. The Monitoring Team had established a new metric for compliance with this Provision, elements of which are described above. Because the Facility continued to comply with all but the new requirement, a finding of substantial compliance will be maintained; however, the new criterion must be met at the next review to maintain compliance.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough 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.	According to DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) the policy: ▪ Did describe in a comprehensive fashion the conduct of all such investigations; ▪ Did require that investigators be qualified, requiring that Investigators complete training in Comprehensive Investigator Training (CIT0100), People with MR (MEN0300), Conducting Serious Incident Investigations or Fundamentals of Investigation (INV0100), and, a class in Root Cause Analysis. ▪ Did require that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and ▪ Did require that investigators be outside of the direct line of supervision of the alleged perpetrator. Training curricula were reviewed for Department of Family and Protective Services (DFPS) and Facility investigators. This review of material used by DFPS in training its investigators revealed the following:	Substantial Compliance

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		The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 4. Time and Stress Management In reviewing the materials associated with these modules the Monitoring Team is of the opinion that this training is competency-based and meets the requirements of the SA. DADS policy reported that Facility Investigator training is to consist of the following classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. MEN0300 People with Mental Retardation 4. CIT0100 Comprehensive Investigator Training, or LRA training Conducting Serious Investigations 5. Root Cause Analysis The Monitoring Team believes this training, if completed as described, was adequate for the conduct of investigations at the Facility, was competency based, and meets the requirements of the SA. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. While not required it appears most investigators also take a class titled "MH&MR Overview – APS Investigator	

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		Role." Completion of this class would demonstrate additional training in working with people with developmental disabilities. The training records for DFPS investigators were reviewed with the following results: ▪ Five out of five DFPS investigators (100%) had completed the requirements for investigations training. ▪ Five out of five DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The training records for Facility investigators were reviewed with the following results: ▪ Ten out of 10 Facility investigators (100%) had completed the requirements for investigations training. None of the staff designated as investigators had supervisory responsibilities that extend beyond the Incident/Risk Management Department; therefore, they are unlikely to be in the direct line of supervision of anyone subject to investigation. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management), Facility staff was required to cooperate with outside entities conducting investigations of abuse and neglect. This included DFPS and OIG. As described above with regard to Provision D.2.a, two samples of investigation files were selected for review. These included Sample D.1 and Sample D.2, which consisted of DFPS investigations, and Facility investigations, respectively. Review of the investigation files in Sample D.1 showed that in 14 out of 14 investigations (100%), Facility staff cooperated with outside entities, including DFPS and OIG. Review of the investigation files in Sample D.2 showed that in nine out of nine investigations (100%), Facility staff cooperated with any outside entities inquiring about the Facility investigation. Outside investigators (DFPS and OIG) reported cooperation from Facility administrative staff in the conduct of their investigations. Additionally, the DFPS Supervisor who oversees Facility investigations regularly participates in New Employee Orientation at the Facility. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
	(c) Ensure that investigations are	The Memorandum of Understanding, dated 5/28/10, provided for interagency	Substantial

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	coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 14 investigation records from DFPS (Sample D.1), eight were allegations of physical abuse. Seven of eight (88%) had been referred to law enforcement (Office of Inspector General). For these seven (100%) there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the nine investigation records from the Facility (Sample D.2), none had been referred to law enforcement agencies because none were appropriate for referral. Outside investigators (DFPS and OIG) reported no issues associated with the coordination of investigatory activity either between the outside agencies or with the Facility. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision. Based on this review the Monitoring Team determined this Provision was in compliance. DFPS had demonstrated a consistent practice of referring all physical abuse allegations to law enforcement (OIG) over the last several reviews and this one instance was likely an oversight in attention to detail rather than a conscious decision to not report the allegation to law enforcement. Nevertheless, DFPS will need to report 100% to maintain compliance at the next visit.	Compliance
	(d) Provide for the safeguarding of evidence.	According to DSSLC policy CMGMT-01B (Incident Management), the Facility is to take steps to preserve physical evidence and should prioritize the collection of evidence that is most at risk of contamination (the Facility policy further states that "in most cases the highest priority will be to identify interviewees and physically separate them until they have been interviewed." This statement is also in DADS policy.).	Substantial Compliance

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		While on site, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence. Evidence was stored in a secure area. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Samples D.2): ▪ Physical evidence that needed to be safeguarded was safeguarded in all DFPS investigations; and ▪ Physical evidence that needed to be safeguarded was safeguarded in all Facility investigations. With regard to testimonial evidence, as noted above both Facility and DADS policy states "the facility investigator should prioritize the collection of evidence that is most at risk of contamination. In most cases, the highest priority will be to identify interviewees and physically separate them until they have interviewed." Evidence gathered through interview is considered testimonial evidence. While not physically separating witnesses the Facility had taken a positive step to protect the integrity of testimonial evidence by implementing a Testimonial Evidence Acknowledgement Form (TEAF). This form reads: "All DSSLC staff has the responsibility to cooperate with all investigations, including DFPS, OIG, and the facility and have the same expectations that they will not interfere with the investigation. 1. If you are the alleged perpetrator (AP) you cannot have any contact with co-workers concerning facility matters, any other matters related to your regular duties, about abuse and neglect cases or any other investigations during hours or after hours. While temporarily reassigned it is important that you not talk about your investigation or engage in conversation with other alleged perpetrators about theirs. 2. If you are the reporter or a witness, you cannot discuss any details of the investigation with anyone, during hours or after hours as kit is very important to protect the integrity of all investigations (DFPS, OIG, and Facility) Failure to comply with the investigators and the terms of this agreement can result in disciplinary action." This statement is signed by the AP/witness and countersigned by the Facility investigator who reviewed its contents with the AP/witness. Additionally, DFPS had added standard language to its report of initial investigatory steps that reads the investigator: "directed the facility to protect the client and the evidence; including taking the appropriate steps to ensure possible alleged perpetrator and witnesses do not discuss the investigation."	

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		The above notwithstanding, the Monitoring Team found little evidence that would suggest that component of the Facility and DADS policy (separation of witnesses until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations) there was no indication that collateral witnesses had been physically separated pending interview. As a practical matter this would be difficult since DFPS usually does not complete interviews of collateral witnesses or alleged perpetrators (APs) until days after the allegation was reported. Based on this review the Monitoring Team determined this Provision was in compliance. The Facility and DADS should review its policy with respect to testimonial evidence. It would be helpful if DADS provided guidance to the Facility as to how this policy should be implemented, or change the policy such that it establishes requirements that can be reasonably administered**.**	
	(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.	Based on Facility policy CMGMT-01B (Incident Management) investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Did require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Thirteen of 14 (93%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples of investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: 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	Noncompliance

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		(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. Case 42744590 contained conflicting information that prevented a determination. The "date and time of initial APS notification" was 5/14 at 8:26am. The "date and time of Superintendent/Director notification" was 5/14 at 2:19am, six hours before the incident was reported to DFPS. Following the visit, the Facility informed the Monitoring Team that the intake was originally generated at 1:51 am, but the format was incorrect, and it was entered again at 8:26 am. DFPS had added standard language to its report of initial investigatory steps that reads the investigator: "directed the facility to protect the client and the evidence; including taking the appropriate steps to ensure possible alleged perpetrator and witnesses do not discuss the investigation." ▪ Twelve of 14 (86%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; ▪ For the two that were not completed within 10 days, two (100%) had documentation of a written extension request that had been approved by the DFPS Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ Therefore, 14 of 14 (100%) were either completed within 10 days or received an appropriate extension. ▪ Fourteen (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ DFPS concerns and recommendations for corrective action were included in four investigation reports and were appropriate to address issues identified by the DFPS investigator. <u>Facility Investigations (Sample D.2)</u> The following summarizes the results of the review of Facility investigations of serious incidents: Nine of nine (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing the UIR and determining the time of the first entry indicating any on site work activity by a facility investigator. Seven of nine (78%) were completed within 10 calendar days of the incident (or had an	

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		approved extension), including sign-off by the supervisor. UIRs 129 and 194 did not. Nine of nine (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are presented in Provision D.3.f of this report. In all nine of the investigations reviewed (100%), recommendations for corrective action were included. In all nine of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation. None of the investigation reports contained an explicit determination (during or at the conclusion of the investigation) that abuse or neglect was, or was not, the cause of or a contributing factor to the incident. The first page of each UIR has an entry reporting whether or not the "type of investigation" is abuse or neglect. The Monitoring Team does not view this entry as representing a conclusion reached during or at the end of the serious incident investigation. This determination is particularly important in an investigation of a serious discovered injury, which was the case with five of the nine serious incidents in Sample D.2. This was missing from UIRs 212, 261, and 236. Without this determination an investigation of a serious injury cannot be considered thorough and complete. Based on this review this Provision is not in substantial compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: Facility investigations need to be completed within the required timeframes and must make an explicit determination as to possible abuse/neglect in order to determine what, if any, corrective recommendations need to be made in the written report.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all	Based on the Monitoring Teams' review of DADS revised Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 12 out of 14 investigations reviewed (86%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. For case 42752511 (inconclusive physical abuse) the investigator deemed the testimonial evidence provided by the alleged victim as credible and the testimonial evidence	Noncompliance

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	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.	of the alleged perpetrator and two witnesses as questionable, one of whom provided testimony that was inconsistent with what was captured by the video surveillance cameras. It appeared to the Monitoring Team that this allegation of physical abuse could have been substantiated. For case 42725093 (inconclusive neglect) interviews were not conducted with either the examining nurse or the physician, both of whom could have had information relevant to the injury associated with the alleged neglect. This may have enabled a finding other than inconclusive. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 14 (100%), each unusual/serious incident or allegations of wrongdoing; o In 14 (100%), the name(s) of all witnesses; o In 14 (100%), the name(s) of all alleged victims and perpetrators; o In 14 (100%), the names of all persons interviewed during the investigation; o In 14 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 14 (100%), all documents reviewed during the investigation; o In 14 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. While the reports include "all sources of evidence considered" (in reaching disposition conclusions) in some cases not all evidence was considered. For example, case 42725083 (inconclusive physical abuse and neglect with a serious injury) did not include an interview with a physician or the Facility's nurse that conducted the initial injury assessment who would appear to have had relevant information; o In 14 (100%), the investigator's findings; and o In 12 (86%), the investigator's reasons for his/her conclusions. For case 42752511 (inconclusive physical abuse) the investigator deemed the testimonial evidence provided by the alleged victim as credible and the testimonial evidence of the alleged perpetrator and two witnesses as questionable, one of whom provided testimony that was inconsistent with what was captured by the video surveillance cameras. It appeared to the Monitoring Team that this allegation of physical abuse could have been substantiated. For case 42725093 (inconclusive neglect) interviews were not conducted with either the examining nurse or the physician, both of whom could have had information relevant to the injury associated with the alleged neglect. This may have enabled a finding other than inconclusive.	

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		Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ In seven out of nine investigations reviewed (78%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The exceptions were UIRs 145 and 129. Both were discovered serious injuries categorized as "determined cause." Neither investigation contained sufficient evidence to make a determination of cause. UIR 145 only reported "it was decided" what happened, without corresponding evidence or a logical presentation of a sequence events leading up to the serious injury (fractured clavicle). Additionally, video review that may have helped answer some unanswered questions was not used. UIR 129 based the determination of cause on "common knowledge of persons behavior" when it could have been just as plausible a hypothesis that the serious injury (head laceration) was caused by abusive staff, inappropriate handling of the Individual, or interaction with a peer. Neither should have been classified as determined cause. ▪ The report utilized a standardized format that set forth explicitly and separately: o In nine (100%), each unusual/serious incident or allegations of wrongdoing; o In nine (100%), the name(s) of all witnesses; o In nine (100%), the name(s) of all alleged victims and perpetrators; o In nine (100%), the names of all persons interviewed during the investigation; o In nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In nine (100%), all documents reviewed during the investigation; o In nine (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In nine (100%), the investigator's findings; and o In seven (78%), the investigator's reasons for his/her conclusions. The exceptions were UIRs 145 and 129. Both were discovered serious injuries categorized as "determined cause." Neither investigation contained sufficient evidence to make a determination of cause. For UIR 145 the investigation conclusion was reported as "it was decided" what happened without correlating evidence or a logical presentation of a sequence events leading up to the serious injury (fractured clavicle). Additionally, video review that may have helped answer some unanswered questions was not used. For UIR 129 investigation conclusion was reported as "common knowledge of persons behavior"	

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		when it could have been just as plausible a hypothesis that the serious injury (head laceration) was caused by abusive staff, inappropriate handling of the Individual, or interaction with a peer. Neither should have been classified as determined cause. Additionally, possible issues associated with specific staff assignments and responsibilities associated with supervision and care of Individuals were not always 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. Based on this review the Facility is not in 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 thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ The DFPS investigations in Sample D.1 did not meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; ▪ Fourteen of 14 (100%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation. ▪ The Facility Director/Incident Management Coordinator did accept (meaning did not formally question DFPS further) at least ninety-four percent of the investigations over the six months prior to the onsite review. Issues ancillary to the allegation DFPS investigated were often identified and stimulated an additional Facility investigation. The Monitoring Team views this as a good practice. ▪ For two of the DFPS investigation files the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. Based on a review of the Facility's data, for neither (0%), the Facility correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Nine of nine (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation.	Noncompliance

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		▪ In nine of nine investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ For nine (100%), the supervisor had identified concerns, most being non-substantive technical corrections. For these investigations, for nine (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ For the nine investigations noted above the Monitoring Team identified deficiencies in four (44%). The supervisory review did not appear to address these deficiencies. This was the case with UIRs 196 (injury report says injury was witnessed but video review shows it was not), UIR 170 (contains no recommendations for future actions despite this being an incident of unauthorized departure resulting in the Individual getting onto a busy highway), and UIRs 129 and 145 (insufficient evidence to conclude a determined cause of a serious injury – refer to Provision D.2.f). Based on this review this Provision is not in substantial compliance.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility-only investigations did not meet the requirements outlined in Section D.3.f. This Provision is not in substantial compliance.	Noncompliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. For investigations in Sample D.1 and D.2 in which disciplinary action was warranted in all cases (100%), prompt and adequate disciplinary action had been taken and documented. For investigations in Sample D.1 and D.2 for which recommendations for programmatic action were made, the following was found: ▪ For all (100%), prompt and thorough programmatic action had been taken and documented. ▪ For all (100%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was	Noncompliance

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		modified. Note: no evaluation was undertaken that addressed any underlying issues, only that each specific problem (e.g. an environmental hazard) or a specific staff mistake (e.g. breach of level of supervision) was addressed. While the IMC and his staff kept track of all recommendations and tracked implementation to conclusion, it did not appear from meeting minutes and observation that the IMRT maintained any detailed role in oversight of the execution of disciplinary and programmatic actions necessary to correct a situation and/or prevent recurrence except to the extent that the Chair of the IMRT (the IMC) did so. The Facility presented insufficient documentation to validate that: ▪ The IMRT considers and accepts or provides a reason for not accepting recommendations in the DFPS or UIR reports. Those accepted recommendations are carried through to conclusion. The Facility documents the completion of the recommendations. ▪ The IMRT identifies the timeframes in which actions should be taken, and these are reasonably based on the seriousness of the issue and the time necessary for the action to be completed. Timeframes are adhered to. ▪ In accepting recommendations, the IMRT identifies the expected outcomes (e.g., competency of staff, modification of a physical environment, changes in practices, reduction in an at-risk behavior, etc.). The Facility has a system to confirm that expected outcomes were achieved, and documented this process for each recommendation (e.g., based on retraining, staff had passed a competency test or during interview could provide relevant information; observation of a change in physical environment; observation or documentation review to confirm a change in practice; behavioral data showing a change in behavior; etc.). Based on this review this Provision is not in compliance.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Based on review of DSSLC policies CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) records of every investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, electronic data systems are maintained which allow the IMC to sort investigation records by name of the alleged perpetrator or by name of the alleged victim. The IMC reported that DFPS also has a data management system that allows a search of prior case history of alleged perpetrators and alleged victims. Additionally, DFPS, if necessary, can obtain these data from the Facility. For Facility investigations, these data are included in the UIR template which enables the Facility investigator to determine its relevance to each investigation.	Substantial Compliance

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		Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
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.	For all categories of unusual incident categories and investigations, the Facility did have a system that allowed tracking and trending by: ▪ 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. Over the past two quarters, the Facility's trend analyses: ▪ Were conducted at least quarterly; ▪ Did address the minimum data elements; ▪ Did use appropriate trend analysis procedures; ▪ Did provide a narrative description/explanation of the results and conclusions; and ▪ Did, as appropriate, contain recommendations for corrective actions. Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified and an action plan was needed, action plans were developed. As appropriate, action plans were developed both for specific individuals and at a systemic level. The trend reports and/or minutes did not show that action plans were implemented and tracked to completion. These data were separately maintained by the QA department and reported to the IMC at monthly section lead meetings between the section lead, Settlement Agreement Coordinator, and QA Director. These data were also reported to the QA/QI Council. This process included review, as appropriate, of the effectiveness of previous action plans. At the time of this review the Facility had initiated two action plans related to Section D of the SA. Based on a review of resulting action plans and documentation related to implementation: ▪ Two out of two action plans (100%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified	Noncompliance

#	Provision	Assessment of Status	Compliance
		the person(s) responsible, timelines for completion, and the method to assess effectiveness. ▪ For neither action plan reviewed (0%), the plan had been timely and thoroughly implemented. ▪ For neither action plan (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. Based on this review this Provision is not in compliance. Improvement is needed in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs).	
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.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 24 employees and nine volunteers confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. 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. 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	Substantial Compliance

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		described, is in place at the Facility. The Monitoring Team has determined that the DSSLC was in substantial compliance with this component of the SA.	

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 3. DSSLC Section E Presentation Book 4. DADS Policy 003.1 - Quality Assurance 1/26/12 5. DSSLC Policy CMGMT-15 Quality Assurance 9/1/12 6. DSSLC QA Plan 5/1/13 7. Quality Assurance/Quality Improvement Council meeting minutes since the last review 8. Facility Trends Monthly Meeting minutes January to June, 2013 9. Monitoring tools and guidelines for each provision of the SA (various dates) used by QA department 10. Monitoring tools used by departments/disciplines 11. Corrective Action Plans (CAPs) initiated since January, 2013 (51) 12. CAP tracking logs and related documentation **People Interviewed:** 1. Lori Powell, Director of Quality Assurance **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 7/25/13 2. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 7/24/13 3. Critical Incident Team (7/25/13)
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E. 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. For Section E, in conducting its self-assessment, the Facility reviewed the QA policy, data inventory lists, the QA plan and matrix, the monitoring tools used by the QA department as well as those used by other departments including inter-rater reliability checks, and QA/QI Council activities. The Facility QA Department did not use any specific monitoring tools in assessing compliance with Section E. The Facility did not always present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by departments and disciplines resulting in overly broad and generic statements, for example "data from monitoring tools for each department are reviewed with section leads each month in order to assist with the analysis of data," or, "not all sections of the settlement agreement have inter-rater reliability." It was evident to the Monitoring Team that the Facility had made substantial progress since the last review but had not as yet fully operationalized the comprehensive QA program described in policy. Different departments and disciplines were at different stages of QA implementation. The QA self-assessment should be more detailed describing implementation status by department/discipline.

	The Facility rated itself as being in compliance with Provisions E.2 and E.3 of Section E. This was not consistent with the Monitoring Team's findings. The Monitoring Team determined compliance only with Provision E.3. Provision E.2 was not in compliance because not all monitoring tools had been in place long enough to provide useful longitudinal data and not all monitoring had inter-rater reliability. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Action steps were overly general and were not targeted at specific actions for specific departments and disciplines at the Facility. For example, the primary reason for a self-assessment of noncompliance with Provision E.1 was reported to be lack of inter-rater reliability yet none of the action steps specifically addressed this deficiency either generically or specific to particular departments/section leads. These actions steps did not always provide a set of steps likely to lead to compliance with the requirements of this Section. The Action Plan should include, where appropriate, Action Steps for each department/discipline as well as Facility-wide actions and benchmarks for completion of all required department/discipline steps needed to complete Facility-wide actions.
	Summary of Monitor's Assessment: The Facility demonstrated significant improvement in the development and implementation its QA system and has moved much closer to findings of substantial compliance than noted in previous reports. For example, QA activities noted in previous reports as "in the early stages of implementation" now appear to be routine and the number of monitoring tools that have inter-rater reliability had increased. The Facility QA Director and Settlement Agreement Coordinator meet monthly with each SA Section lead to review data, identify trends, and determine if Corrective Action Plans (CAPs) are needed. The reports prepared by the QA department for the QA/QI Council are extensive and provide much useful data for review, analysis, discussion, and decision-making. Additionally, section leads also prepare narrative information for each report that includes: accomplishments for the last three months; upcoming challenges and plans for overcoming these challenges; data analysis; review of corrective action plan(s); status of policy/procedure review, revisions, and implementation; summary of any relevant committee recommendations; and priorities for the next quarter. The process for inter-rater reliability continues to make progress but is not yet complete. Data tables and graphs presented in the monthly QA/QI Council report included inter-rater reliability data. The Facility developed key indicators (process and outcome) and tracks and trends data related to expected performance. The QA/QI Council regularly reviews key indicator data. The QA/QI Council reviews each section of the SA at least once a quarter. The Facility's data system had achieved a level of maturity such that multiple variables can be examined for most data points.

	During a QA/QI Council meeting observed by the monitoring team, there was active and appropriate participation of attendees. A spirit of teamwork was evident to the Monitoring Team. The Facility processes for initiating, implementing, and tracking CAPs had become more organized than that observed at the last review, but there are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems. There was not an adequate system for tracking the status of CAPs. Of the CAPs being tracked by the Facility, none included any action taken if a CAP had not been implemented fully or timely. Evidence showing how each CAP was evaluated for effectiveness was not apparent to the Monitoring Team.

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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.	<u>State QA policy</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy 003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QA/QI Council and for statewide discipline QA/QI committees. Neither was in place at this time.	Noncompliance

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		Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. <u>Facility QA policies and practices</u> There were facility policies that adequately supported the state policy for quality assurance. The Facility had a Quality Assurance/Quality Improvement (QA/QI) Council required by State policy. Additionally, many other Facility policies contained a QA component within them that complemented the over-arching Facility policy. There was a complete and adequate data list/inventory at the facility and the list was current. The inventory was maintained by the QA Director and was regularly reviewed. The QA plan narrative at the Facility had been updated in May, 2013. The plan is comprehensive and addresses: ▪ a description of the purpose of the QA program, ▪ organizational structure of the QA process (including individual roles and responsibilities), ▪ data list/inventory, ▪ QA matrix, ▪ key indicators, ▪ how data are summarized and analyzed, ▪ the QA report, ▪ QAQI Council and its role in reviewing data and guiding the entire QA process, and ▪ corrective action planning and implementation process The QA plan matrix contained the data to be submitted to the QA department; these data are then included in QA reports and presented to the QA/QI Council. From review of QA/QI monthly reports and interview with the QA Director, the Monitoring Team determined that for the 19 sections of the Settlement Agreement (not including Section E), an adequate set of key indicators were included for 16 of the 19 sections (84%). Of these 16, both process and outcome indicators were identified for seven (44%). Of these 16, in 16 (100%) the indicators provided data that could be used, if appropriate, to identify the information specified in requirements for Provision E1: 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, as necessary and appropriate to each key indicator. The Facility's data system had achieved a level of maturity such that multiple variables can be examined for almost every data point.	

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		Examples of key indicators used at the Facility for which data is tracked and trended included: 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. The QA plan matrix included all self-monitoring tools and self-monitoring procedures. All data that QA staff members collect were listed on the matrix. All of the items in the QA plan matrix also appeared in the QA data list/inventory. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that of the 69 items in the QA plan matrix, 58 (84%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). Those that were not had not been in an implementation stage for a full six months or had been revised and now have different data elements being tracked. Examples include the Injury Audit Record Review and the Engagement/Meal Monitoring tool. Of the 69 items in the QA plan matrix, 58 (84%) were documented to show review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). Those that were not had not been in an implementation stage for a full six months or had been revised and now have different data elements being tracked. Examples include the Injury Audit Record Review and the Engagement/Meal Monitoring tool. At the time of the review, of the 69 components of the QA plan narrative and QA plan matrix, the Facility implemented 69 (100%). Documentation and observation indicated that QA staff assisted each discipline in analysis of data. The QA Director and Settlement Agreement Coordinator met monthly with each SA Section Lead for this purpose. Of the 69 self-monitoring tools for the SA, the content of 69 (100%) appeared to be appropriate and the QA Director reported 69 (100%) were reviewed within the past six months, and revised as appropriate. Much of this occurred in the context of updating the QA plan in May. Of the 69 self-monitoring tools for the SA, 45 (65%) had adequate formal instructions and guidelines for the user. Note: the 69 self-monitoring tools include those required by	

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		DADS for statewide use (19) and tools developed by the Facility for local use. QA Auditors implement monitoring using these tools in addition to monitoring done by the departments; the purpose for this additional monitoring is primarily to determine reliability of observations. While the tools typically measure the same things the formality of instructions is variable. For example, most of the 19 tools issued by DADS and used statewide have formal instructions. Tools developed for local use at the Facility may or may not have formal instructions and guidelines. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the self-monitoring tools for the 19 sections of the SA (one is not expected for Section E), seven (37%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-rater reliability). Those that did not lacked sufficient QA department monitoring for inter-rater reliability. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the 19 sections of the SA, there was documentation that the implementation (not including inter observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for 19 (100%) of the 19 sections. Based on this review the Monitoring Team determined this Provision was not in compliance. The Facility had made substantial progress since the last review. QA activities noted in previous reports as "in the early stages of implementation" now appear to be routine. The number of monitoring tools that have inter-rater reliability had increased; however the lack of inter-rater reliability is the primary barrier to compliance with this Provision.	
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	All data in the QA plan matrix should be summarized, graphed, and analyzed by discipline department with oversight and assistance as needed by the QA department. Data from the QA plan matrix for 19 of the 19 (100%) sections of the SA (not section E) were summarized, graphed showing trends over time, and analyzed across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as appropriate to the indicator being measured. As reported in Provision E.1, the Facility reported that 58 of 69 (84%) of the monitoring tools used by the Facility had been in place for longer than six months. Therefore, not all monitored elements of some of the sections of the SA had been used long enough to	Noncompliance

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	which each action step must occur.	permit assessment of trends. Since the last onsite review, a meeting occurred between discipline/department staff and QA staff at least twice for 19 of the 19 (100%) sections of the SA. These meetings included: o A review of the data listing inventory and matrix, o Discussion of data and apparent outcomes, o A review of the conduct of the self-monitoring tools, o The creation of corrective action plans as appropriate, o A review of previous corrective action plans. Since the last onsite review, data were available during these meetings to facilitate department/discipline review and analysis with QA staff; however, as noted above, the Facility reported that 58 of 69 (84%) of the monitoring tools used by the Facility had been place for longer than six months. As a result in some areas there was not sufficient longitudinal data available to permit meaningful review and analysis. Since January 1, 2013 the Facility had initiated 51 Corrective Action Plans (CAPs). The origin of each CAP was not clear. It could not be determined which CAPS resulted from review and analysis of data that occurred at a discipline/department meeting, a discipline/department meeting that included QA staff, by QA staff, or as a result of a recommendation at a QA/QI Council meeting. One purpose of regularly scheduled data reviews by QA staff with discipline/department staff is to identify trends and other conditions that signal a need for initiation of a CAP. In the future, CAPs should note the origin. Since the last onsite review, a facility QA report (for dissemination at the Facility and for presentation to the QA/QI Council) was created for nine of the nine months. Of the 20 sections of the SA, all 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the SA that were presented, 11 of 20 (55%) consistently contained the following components: 1. Self-monitoring data (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate) 2. Key indicators (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate). 3. Narrative analysis The Facility reported that as the QA system had matured changes were made to some	

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		monitoring tools. As a result certain data elements would only be present for some of the rolling 12 months making tracking and trending less useful in those areas. There was an adequate description of the QA/QI Council in the QA plan narrative and in a separate QA/QI Council policy or procedure document. Since the last onsite review, the QA/QI Council met at least once each month. In fact, the Facility regularly convened two meetings a month. One focused exclusively on the SA and included a presentation for several sections of the SA. Each SA section on a particular months agenda reported on: 1. Accomplishments for the last three months. 2. Upcoming challenges and plans for overcoming these challenges. 3. Data analysis 4. Review of Corrective Action Plan(s) 5. Status of policy/procedure review, revisions, and implementation 6. Summary of any relevant committee recommendations 7. Priorities for the next quarter Agendas were structured so that each Section of the SA was reviewed at least once every three months. The second QA/QI Council meeting of the month was referred to as a "project meeting." Its agenda typically covered topics that were relevant to Facility-wide information sharing and decision-making. Some topics were SA agreement related and some were not, for example, an upcoming highway construction which will have a significant impact on Facility operations, or budget management issues. Minutes from 18 of the 18 (100%) QA/QI Council meetings since the last review indicated that the meeting occurred according to schedule. Minutes from 18 of the 18 (100%) QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, Minutes from 18 of the 18 (100%) QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from 18 of the 18 (100%) QA/QI Council meetings since the last review documented that (a) data from QA plan matrix (key indicators, self-monitoring) were presented, (b) the data presented were trended over time, (c) comments, interpretation, and analysis of data were presented. As reported in Provision E.1 some Monitoring Tools had not been in use long enough to permit meaningful review of longitudinal data.	

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		In nine of the 18 QA/QI meetings (50%), recommendations and action plans were selected when appropriate to do so, and were based on the data presented. This was appropriate; as reported earlier, the other nine QA/QI Council meetings serve a different purpose. During a QA/QI Council meeting observed by the Monitoring Team, there was active and appropriate participation of attendees other than the presenter for seven of the seven (100%) reports/data presented during the meeting. A spirit of teamwork was evident to the Monitoring Team. The Facility processes for initiating, implementing, and tracking CAPs had become more organized than that observed the last review. There are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems. An adequate written description did exist that indicated how CAPs are generated, including the criteria for the development of a CAP. Generally, CAPs were required when monitoring data showed performance indicators were not at, or had dropped below, a pre-determined threshold (for example, 85%). The Facility could benefit by distinguishing some CAPs as high priority where the problem being addressed is critical to Individual safety and protections. The current system at the Facility seems to treat all CAPs as if they were equal in importance. When considering the full set of CAPs, they did appear to have been chosen following the written description policy or procedure. Of the 15 CAPs reviewed by the Monitoring Team, 15 (100%) appeared to appropriately address the specific problem for which they were created. Based on a sample of 15 CAPs, which represented 29% of the total of 51 CAPs initiated since January 1, 2013: • 15 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 15 (100%) included the anticipated outcome of each action step. • 15 (100%) included the person(s) responsible. • 15 (100%) included the time frame in which each action step must occur. Based on this review this Provision is not in substantial compliance. Significant progress had occurred since the last review but full and complete implementation of data collection, review, and analysis (including inter-rater reliability) had not as yet been	

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		achieved.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of 15 CAPs, which represented 29 % of the total of 51 CAPs initiated since January 1, 2013 there were: • 15 (100%) that included documentation about how the CAP was disseminated, • 15 (100%) that included documentation of when each CAP was disseminated, and • 15 (100%) that included documentation of to whom it was disseminated, including specific person(s) responsible. Based on this review this Provision was in substantial compliance.	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.	Corrective action plans need to be implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified. "Fully" means that all steps of the CAP were implemented, and there was complete implementation of the stated action steps, and "timely" means that the due dates in the CAP were met or a reasonable explanation is provided for any delays. Based on a review of 51 CAPs initiated since January 1, 2013 five (10%) were implemented fully and 11(22%) were implemented in a timely manner. There was not an adequate system for tracking the status of CAPs. Of the CAPs being tracked by the facility, all indicated the status of the CAP (open/closed) but none included any action taken if a CAP had not been implemented fully or timely. The Facility QA director did maintain summary information regarding CAPs and their status that was updated within the month prior to the onsite review. This information is discussed at the monthly department/discipline meetings with the QA Director and presented to the QAQI Council at least quarterly. Based on this review this Provision is not in compliance.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Evidence showing how each CAP was evaluated for effectiveness was not apparent to the Monitoring Team. The CAP log included a column labeled "evidence proving effectiveness" but this did not provide data to substantiate effectiveness. Often, the Monitoring Team was directed to review data in QA/QI Council reports. It was difficult to inter-relate data trends (showing improvement) to a particular CAP and the action steps contained in the CAP. The Facility needs to develop a more articulate system for displaying CAP actions, intended outcomes (in most cases expressed as data elements), and actual outcomes (in most cases expressed as data elements).	Noncompliance

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		Data presented to the Monitoring Team indicated no CAPs had been subject to revision since June, 2012. Because of the absence of clear articulation of expected CAP outcomes, and corresponding outcome data, it was not possible for the Monitoring Team to determine if any CAPs should have been modified. Similarly, it would be unlikely the QA/QI Council could make such a determination except if using anecdotal information. Based on this review this Provision is not in compliance.	

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 7-8-2013 2. Denton State Supported Living Center Action Plans, updated 6-21-2013 3. Denton State Supported Living Center Report for Monitors 4. Section F Presentation Book materials 5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10 6. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/2012 7. Draft DADS Policy 017: Habilitation, Training, Education and Skill Acquisition Programs, effective 5/10/12 8. DSSLC Policy CMGT 12: Personal Support planning Process (Integrated Protections, Services, Treatments and Supports, dated 08/05/11 9. DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, Exhibit K: Increasing Individual's Participation at Their Own ISP Meeting, dated 5/17/13 10. Plan to Support People to Live in the Most Integrated Setting of Their Choice, undated 11. Compliance per Individual-Annual Assessments 4/1/2012-4/1/2013, dated Thursday, June 13, 2013 12. ISP Dates by Individuals, dated Thursday, June 06, 2013 13. Monthly Attendance by Discipline by Discipline PSPs Only, 12/1/2012-5/31/2013 14. ISP Attendance Summary, undated 15. ISP assessments for Individuals #42, #212, #231, #288, #317, #379, #463, #490, #520, #567, #667, #694, #770, #772, and #788 16. Compliance per Individual-Annual Assessments, dated 1/1/2013-1/31/2013, 2/1/2013-2/28/2013, 3/1/2013-3/31/2013, 4/1/2013-4/30/2013 17. Overall Compliance by Unit-Timeliness of Assessments 18. Monthly and Quarterly Reviews for Individuals #42, #212, #288, #317, #379, #463, #490, #567, #694, #770, #772, and #788 19. Civil Rights Training i-Learn course material, accessed 7/2/2013 20. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #42, #231, #288, #317, #490, #567, #667, #772, and #788 21. Individual Support Plans (ISPs) and ISP assessments for new admissions: Individuals #212, #379, #463, #694, and #770 22. Section F materials from the QA/QI Report, dated February 28, 2013 **People Interviewed:** 1. Clark Clermont, Director of Community and Family Relations (CFR) 2. Frank Padia, Facilitator Coordinator 3. Leslie Clark, Qualified Developmental Disabilities Professional (QDDP) Coordinator 4. Lori Powell, Director of Quality Assurance 5. Dora Tillis, Assistant Director of Programs 6. Marty Mapp, Lead QDDP **Meeting Attended/Observations:**

	1. Annual ISP meetings for Individuals #231 and #667 2. ISP Preparation meeting for Individual #608
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. 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. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The self-assessment rating relied to a large extent on data collected through the Facility's QA/QI processes, including the Integrated ISP Monitoring Tool. The Facility indicated it was not in compliance with any of the Provisions of this Section and the Monitoring Team concurred. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. There were several instances in which sections of the Self-Assessment made reference to the Action Step that would be implemented to address the reasons for noncompliance. This was a positive step, as it tied the Self-Assessment and Action Plans together to an extent. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. The assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. A summary of noted progress included: The Facility was undertaking a significant effort to improve on its processes to better support individual understanding of and participation in the ISP process. The goal of this process was to ensure the individual and the team work together in developing a service plan that is person centered. All QDDPs had received training related to this process. The Monitoring Team commends this overall initiative and believes it holds promise toward achieving compliance with this provision and, more importantly, for supporting individuals to participate fully in planning for their own futures. In addition, The Monitoring Team observed there was progress in the actual timely completion of the QDDP monthly reviews and the substance of the recent monthly notes. The Facility continued to take and/or plan actions designed to promote accessibility and comprehensibility of the ISP. Finally, the Facility was to be commended for its efforts toward developing a comprehensive quality assurance system for this Section. **Provision F1:** This provision was not in compliance**.** A revised ISP format and process had been implemented and considerable training and coaching had been provided to the QDDPs and IDTs. The new

	process included an ISP Preparation meeting held approximately three months prior to the ISP annual meeting as a means of ensuring adequate IDT preparation for the latter. The Monitoring Team found this to be a particularly promising practice that had already resulted in improved preparation and participation by IDT members as observed in the annual ISP meetings held during this site visit. Overall, however, the revised ISP process was still meeting with limited success specific to the requirements of this section of the SA. IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. **Provision F2:** This provision was not in compliance**.** ISPs reviewed lacked many of the criteria specified in the SA for this Provision. ISPs still did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. Skill acquisition programs were not yet sufficiently constructed or assessed for progress. The Monitoring Team found ISP strategies still did not reflect encouragement of community participation in any meaningful or purposeful manner. As noted in the summary of progress above, the Facility was to be commended for its efforts toward developing a comprehensive quality assurance system for this Section. These processes were continuing to develop; based on the outcomes at this time, it was not yet clear the processes were effective in terms of identifying and remediating issues that would ensure ISPs are developed and implemented consistent with the provisions of this section.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
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 Intellectual Disabilities Professional (QIDP), also known as Qualified Developmental Disabilities Profession (QDDP), was the one person assigned to each individual to facilitate the work of each IDT. <u>Staffing of QDDP Department</u> The Facility reported that it had 30 QDDP positions, including four Lead QDDPs. There were also a QDDP Coordinator and a QDDP Educator. All individuals had an assigned QDDP. The QDDP/individual ratio appeared to be sufficient based on the workloads of staff as it affected their abilities to manage and complete their tasks in an adequate and timely manner. <u>Process of determining competency of QDDPs in the facilitation process</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on the list provided, nine of the 30 QDDPs (30%) had been deemed fully competent in facilitation. The Facility was using the Q Construction Facilitation curriculum for training in this area and evaluating competence, although the current focus was on hands-on modeling and mentoring being provided by the designated facilitators and the Lead QDDPs. It had also devoted considerable resources to training for QDDP staff, as described further in Provision F2e. The results of the additional training and support were evident in the more organized manner in which the ISP annual and ISP Preparation meetings were completed and in the facilitation of the participation of the IDT members at the meetings. This represented progress over the previous site visit; however, outcomes in terms of improvements in ISPs were not yet substantial. For example: • For none of the nine plans reviewed, (0%) did the facilitation process result in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. • For only one of the nine ISPs reviewed (11%) the facilitation process resulted in an adequate discussion of the most integrated setting. • For none of the two ISPs annual meetings observed (0%) the facilitation process resulted in the adequate participation of the individual, although progress was noted. See Provision F1b. The assigned QDDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found in its review of the focus sample that there was some progress noted over previous visits, but the QDDPs did not yet consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. Conclusion: This provision was found to be not in compliance.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	<u>Composition and Participation of IDT:</u> DADS Policy 004.1: Individual Support Plan Process, clearly identified requirements for interdisciplinary team (IDT) composition, attendance, and participation, and the processes for ensuring them. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the annual planning meeting and record this in the Attendance-Assessment checklist. The Facility provided a document entitled Monthly Attendance by Discipline PSPs Only, 12/1/2012-5/31/2013; however, it indicated the State-wide ISP tracking Database did not accurately track the attendance of required participants at this time and could not produce reliable summary data relative to ISP attendance. For its self-assessment, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		Facility reviewed a random sample of 63 ISP sign-in sheets to review IDT member participation, with the following results: • Sixty-two (98%) had a representative from Habilitation Therapy • Sixty-two (98%) had a representative from Vocational/Day Programming • Twenty-seven (43%) had a representative from Dietary/Nutrition • Zero (0%) had a representative from Dental • Thirty (91%) of the 33 who receive services from Psychiatry) had a representative from Psychiatry. • Fifty-seven (91%) had a representative from Direct Support. • Sixty-three (100%) had a representative from Nursing • Sixty-one (97%) had a Primary Care Provider present at the ISP • Thirty-seven (59%) had a representative from Psychology • Sixty-three (100%) had the assigned QDDP present The Monitoring Team reviewed the signature sheets for all eight ISPs held during the week of the site visit. Taking into account the presence of the Monitoring Team as an influence on attendance, the findings were fairly consistent with the Facility's self-assessment. It was noted that there was no attendance by a dentist at any of the meetings in either of these two samples. Other examples of attendance noted: • Seven (88%) included the individual; • Eight (100%) included a Direct Support Professional; • Eight (100%)included the QDDP; • Four (50%) included a family member/LAR or advocate; • Eight (100%)included the Registered Nurse; • Six (75%) included Psychologist or BCBA; • Three (38%) included Active Treatment staff; • Eight (100%)included the Primary Care Physician; • Eight (100%)included a representative from OT/PT • Five (63%)included a Speech Therapist The Monitoring Team also evaluated participation at the ISP Preparation meeting. For the meetings held during the monitoring visit, there was some concern that the commendable intent of the process was undermined by a lack of IDT participation. The number of IDT members participating ranged from three, for two of the meetings, to a high of six. Only one meeting was attended by the individual. <u>Extent of Individual participation in ISP:</u> In addition to actual meeting participation by individuals, meaningful participation remained very limited, as reported in previous assessments by the Monitoring Team. A newly revised Preferences and Strengths Inventory (PSI) process, as described in DADS Policy 004.1:	

#	Provision	Assessment of Status	Compliance
		Individual Support Plan Process, was not robust enough to facilitate an individual's real understanding and participation. As observed in previous reports, 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 Director of CFR reported the Facility was undertaking a significant effort to improve on its processes to better support individual understanding of and participation in the ISP process. DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, Exhibit K: Increasing Individual's Participation at Their Own ISP Meeting, dated 5/17/13, described the process as follows: 1) Each individual will have an ISP preparation meeting {ISP Prep) three months before the scheduled ISP meeting. 2) Prior to the ISP Prep meeting a Preferences & Strengths Inventory (PSI) will be conducted with the individual. 3) The ISP Prep meeting will discuss necessary items in preparation for the ISP meeting including discussing options to ensure the individual participates/contributes to the development of their own ISP. "How the person is going to be involved at the ISP meeting should be the first thing discussed."· 4) The options, as guided by the individual's previously identified abilities, to increase participation in the ISP process will be defined by the individual and/or the team members who know the individual best. 1) Once the ISP Prep participants have agreed with an individual's preferred method(s) of participating in their ISP meeting, Life Skills will be informed of the individual's choice. Life Skills programming will then include assisting the individual in preparing for their ISP meeting using individual's choice in how they wish to participate. This programming will occur for three months until the ISP meeting is held. 2) At the ISP meeting the individual will be encouraged to inform the ISP members of their vision for their future; their thoughts, desires, wants, needs and goals they may have. The goal of this process was to ensure the individual and the team work together in developing a service plan that is person centered. All QDDPs had received training related to this process. The Monitoring Team commends this overall initiative and believes it holds promise toward achieving compliance with this provision and, more importantly, for supporting individuals to participate fully in planning for their own futures. This was a new initiative, and implementation and outcomes observed by the Monitoring Team were spotty at this point. For one of two ISPs observed as a part of this sample, it was clear the QDDP had spent time with the individual prior to the meeting and together they had developed some drawings on	

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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>posters to represent interests and goals of the individual. These were posted in the room and referred to throughout the meeting. While the individual was not always clear about what was on the posters and what they signified, overall it was a successful first step at using these kinds of tools. The Monitoring Team applauds the QDDP for this effort. The Monitoring Team also attended an ISP Preparation meeting as a part of its sample for this provision. While the meeting was successful in a number of ways, the individual was not permitted by the LAR to participate in ISP related meetings. The IDT did not have any substantial discussion about how it might facilitate at least some input into the process. The Monitoring Team looks forward to the opportunity to review the outcomes of this initiative at the next monitoring visit.

<u>Conclusion:</u> This provision was found to be not in compliance.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td><u>Extent to which assessments are conducted routinely:</u>
Assessments for the ISP were still not routinely completed on a timely basis, but there was improvement noted. The expectations remained that 1) the PSI would be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individuals' preferences and individual goals into their assessments and recommendations, and 2) the remaining assessments would be posted no later than ten working days prior to the meeting. In the revised ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. The assessments were then to be used by the QDDP to develop an ISP Guide no later than five days prior to the ISP annual meeting.

The Facility reported that progress was being made over previous site visits and included the data, by discipline, represented in the table below:

<table>
<tr><th></th><th>Oct12</th><th>Nov12</th><th>Dec12</th><th>Jan13</th><th>Feb13</th><th>Mar13</th><th>Apr13</th><th>Average</th></tr>
<tr><td>OT/PT</td><td>87%</td><td>89%</td><td>88%</td><td>85%</td><td>85%</td><td>66%</td><td>84%</td><td>83%</td></tr>
<tr><td>SAM</td><td>91%</td><td>90%</td><td>85%</td><td>64%</td><td>75%</td><td>86%</td><td>70%</td><td>80%</td></tr>
<tr><td>Speech</td><td>68%</td><td>68%</td><td>55%</td><td>59%</td><td>45%</td><td>65%</td><td>74%</td><td>62%</td></tr>
<tr><td>Psych</td><td>89%</td><td>72%</td><td>63%</td><td>55%</td><td>62%</td><td>61%</td><td>75%</td><td>68%</td></tr>
<tr><td>Medical</td><td>67%</td><td>56%</td><td>66%</td><td>48%</td><td>51%</td><td>72%</td><td>75%</td><td>62%</td></tr>
<tr><td>FSA</td><td>69%</td><td>44%</td><td>51%</td><td>53%</td><td>72%</td><td>73%</td><td>80%</td><td>63%</td></tr>
<tr><td>Nursing</td><td>87%</td><td>85%</td><td>85%</td><td>69%</td><td>73%</td><td>88%</td><td>82%</td><td>81%</td></tr>
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The Monitoring Team reviewed the timeliness of assessments overall for the sample of</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		completed ISPs, ISP annual meetings held during the monitoring visit and well as for as sample of upcoming ISPs. While assessment of timeliness remained a concern, there was evidence that the Facility was achieving progress in this area. Findings included: • In the sample of seven ISPs completed prior to the monitoring visit, none (0%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. In several instances, assessments were not completed until well after the meeting was held. Overall for this sample, the rate of timeliness was 52%. It was generally not possible to ascertain assessments that might be missing altogether, as few of these had ISP Preparation meeting documentation that prescribed the required assessments; therefore this assessment is based on whether the available assessments were completed prior to ten working days before the ISP annual meeting was held. • For a sample of seven individuals who had ISPs during the week of the monitoring visit, none of seven (0%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. The overall compliance rate was improving, however, at 78%. • The Monitoring Team also viewed the assessments available on the shared drive for Individual #520, who had an annual ISP meeting scheduled within the next ten working days. For 15 of the assessments that were required per the ISP Preparation meeting, 12 (80%) were available. This was consistent with the compliance rate for the ISP annual meetings held during the monitoring visit. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs/ assessments are conducted in response to significant changes:</u> Although progress was noted in discipline specific assessment processes and outcomes throughout this report, noncompliance was found in the following provisions related to the quality of assessments: J6, K5, L1, M2, O2, O8, P1, R2, S2, T1b1, T1b3 and T1d. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. The Monitoring Team also reviewed the assessments used in the ISP held during the on-site visit for Individual #231 and found the following discrepancies and concerns across a number of disciplines regarding their sufficiency to reliably identify the individual's strengths, preferences and needs: • The RN assessment dated 7/07/13 was not updated to include a new diagnosis of Tourette disorder, even though two of the individual's prescribed psychotropic medications were keyed to this diagnosis. • The audiological assessment provided was from 2001, even though the previous ISP and the ISP Preparation documentation both noted re-testing of the individual's left ear was needed.	

#	Provision	Assessment of Status	Compliance
		• The OT/PT Assessment dated 6/20/13 noted that an assessment of oral-motor/eating ability/nutritional status was attempted on 6-26-13 but not completed because the individuals were on a community outing. There was no documentation that further attempts were made. • The FSA dated 7/10/2013 included no recommendations from the QDDP. • The 9/5/2012 ISP indicated a more thorough Psychological Assessment would be completed within 30 days. The Psychological Assessment available in the record during the site visit was dated 10/05/2010. Per the Monitoring Team's request for the assessments to be used for the 7/24/2013 ISP, the Facility provided a Psychological Assessment marked draft with assessment dates of 09/05/12 and 1/13/13. This could not be considered a thorough assessment of current status as it did not incorporate any of the findings and information from the Counseling Assessment and Treatment Plan, dated 4/22/13 and updated 6/4/13. <u>Conclusion:</u> This provision was found to be not in compliance. Assessments were not completed routinely in a timely manner nor were they of adequate quality to reliably identify the individual's strengths, preferences and needs.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	<u>Extent to which assessment results are used to develop ISPs:</u> Current assessment practices at DSSLC, in terms of timeliness, accuracy and thoroughness, did not yet provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were still not completed in time for QDDPs to complete the ISP Guide five days before the ISP annual meeting that would have enabled IDT members to review before the meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this flawed assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. For example: • For Individual #667, whose ISP annual meeting was held during this monitoring visit, the Monitoring Team observed a robust discussion of the individual's preferences and strengths, but these were not adequately represented in the ISP. Refer to Provision F2a2 for additional detail. • As reported in Provisions L1, only five out of ten action plans (50%), as listed on the annual medical assessment, documented a clinically rational action plan for recurrent pneumonia. • As reported in Provision S1, insufficient information was available to support comprehensive conclusions regarding the use of assessments in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		development of skill acquisition programs. Conclusion: This provision was found to be not in compliance.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision 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. 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 IDT needed to make a recommendation to the individual/guardian. The Monitoring Team found the presence of the required determination was improving, but still not being consistently provided. • Of the nine ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. Of the 72 total assessments that were reviewed, 57 (79%) included a determination of whether the individual could be served in a more integrated setting. • Of the 72 total assessments reviewed, six (8%) included substantive recommendations for how the individual's needs could be met in a more integrated setting. • Of the nine ISPs reviewed, one of the individuals (11%) had been referred for transition to the community. For the remaining individuals, seven of eight ISPs (88%) included an independent recommendation from the professionals on the team to the individual and LAR. Of the eight ISPs, however, none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. • The Facility typically did not yet have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2, a very small proportion of individuals living at DSSLC had opportunities to tour community living options prior to a referral being made. The Facility was developing strategies to address this issue. As also described in Provision T1b2, IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. • In five of the seven completed ISPs reviewed, the professional disciplines individually opined the individual could be served in a less restrictive setting in their assessments, but their independent IDT recommendation was that the person would not benefit from moving to such a setting. There was no discussion or rationale provided for why the individual opinions were not reflected in the IDT's independent recommendation. In several instances, the documentation indicated the reason was LAR or individual preference, even	Noncompliance

#	Provision	Assessment of Status	Compliance
		though the IDT was instructed to make the independent recommendation prior to factoring in the LAR and/or individual preference. This phenomenon clearly called for DADS and the Facility to provide guidance and clarification. 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 obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example: • None of eight (0%) of the completed ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. • In none of the eight (0%) that identified LAR or individual choice as a barrier were there specific action plans developed to address these specific barriers other than providing annual CLOIP information and/or Provider Fair invitations. The Monitoring Team also continued to observe in the on-site ISP annual meetings that IDTs were not effectively addressing either the concerns of the LARs or offering information to LARs about the potential benefits of community living. There remained a clear discomfort on the part of the IDT members in this regard. It is difficult to have such a conversation with a reluctant LAR or family member on an annual basis. This review of the recently completed ISPs indicated IDT members continued to need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs over the course of the year. The ISP Preparation meeting also would provide an opportunity to discuss the barriers and plans to address them, particularly in relation to ongoing interactions and discussions with reluctant LARs. <u>Conclusion</u>: This provision was found to be not in compliance. To move in the direction of substantial compliance, the Facility should focus its efforts over the next six months on the following: • Additional policy guidance and training should be provided to require, as a part of the ISP process, the IDT to not only make a determination regarding the most integrated setting appropriate to an individual's needs, but also describe what would be needed in that setting. This process should help to facilitate a discussion and inform the individual and LAR of the potential advantages of community living, such as having more privacy, or living in closer proximity to family. Having accomplished that, the determination of whether or not a referral will be made can be completed in which individual and/or LAR preference would take final precedence. • Clarification should be provided to IDT members as to the intent of the policy guidance regarding their role to make an appropriate independent assessment of the most integrated setting appropriate to an individual's needs.	

#	Provision	Assessment of Status	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. <u>Identification and Use of Individuals' Preferences and Strengths:</u> In the review of nine ISPs, the Monitoring Team found that none (0%) had effectively incorporated individuals' preferences into related action plans. Preferences and strengths identified in the PSI were acknowledged at the beginning of the ISP Preparation meetings and ISPs, but were less seldom reflected in assessments developed for the annual ISP and/or integrated throughout the narrative and/or discussion of the ISP. There was some progress noted in that the Monitoring Team did observe some Action Plans related to preferences, but as reported in Provision S1 a small sample of SAPs reflected no such integration (0%) of preferences. Action Plans to address strengths were not observed, nor did Action Plans developed for various needs also incorporate approaches to integrate strengths in the methodologies. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed:</u> The Monitoring Team found that none of the nine completed plans reviewed (0%) included a list or discussion of prioritized needs in which the IDT clearly indicated whether any needs were to be prioritized for implementation. For the two ISPs observed during the monitoring visit, there was no significant discussion related to prioritizing needs for both individuals. In none of the nine ISPs (0%), including the two for which annual planning meetings were held during this monitoring visit, were barriers adequately identified and	Noncompliance

#	Provision	Assessment of Status	Compliance
		addressed. For example, for Individual #667, the team identified the individual was independent in toileting except for hygiene following a bowel movement, due to a physical disability. This caused him some degree of embarrassment as he highly valued his independence. There was a robust discussion about the possibilities of providing him with and training him to use a bidet, but this discussion was not found in the ISP narrative. The decision noted in the ISP was to discontinue the current toileting SAP, but no further support was defined. Barriers to living in the most integrated setting also did not typically lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of eight (0%) recent ISPs reviewed for which a referral had not been made evidenced proficiency in this regard. For example, for five of eight, the obstacle to community living was reluctance of the LAR, and in some cases reluctance of the individual. The Action Plans did not adequately address this obstacle, as they typically simply indicated that the individual and LAR would be provided information through an invitation to the Provider Fairs and the annual CLOIP process. Also see Provision F1e above. <u>Identification of Supports Needed to Encourage Community Integration</u>: IDTs did not consistently encourage community participation. As reported in Provision S3b, DSSLC collected and presented an abundance of information regarding skill acquisition programs, community outings, and the details of many of the hundreds of reported outings. Due to the weaknesses noted in the assessment for and development of skill acquisition programs, however, it was not possible to determine if the quality of the SAPs and training was commensurate with the quantity. None of the nine ISPs (0%) reviewed or observed included specific skill acquisition action plans for implementation in the community, in which the objective provided a specific purpose and methodology, was couched in measurable terms, and defined a data collection and analysis process. The most successful of the plans reviewed in this regard was for Individual #231. As described in Provision T1b1, Action Plans developed included the creation of "anchors" in the community, which referred largely to being involved in community activities, but it was not clearly defined how these anchors were intended to address specific skill acquisition. The Monitoring Team commends the IDT for its efforts and encourages it to re-examine and clarify the purposes of these strategies as they may relate to specific skill acquisition.	

#	Provision	Assessment of Status	Compliance
		Otherwise, Action Plans that addressed community participation were general in nature and referred to the individual having opportunities for community outings. For example, Individual #667 was to be referred for transition to the community. The only SAP in the completed ISP that even mentioned skill-building for community living was to make a purchase independently. The instructions for this SAP indicated the individual would be assisted to go to the canteen or local grocery store to choose and purchase items that are consistent with the prescribed diet. There was no expectation given, however, for any minimum number of times the training should be completed in the community, nor any rationale for staff provided as to how this would support community living. 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. The ISP Preparation Meeting offered an opportunity to focus the attention of the IDTs on ensuring that each of these requirements is adequately represented in each individual's ISP. The Monitoring Team attended two ISP Preparation meetings and found there were indications the meeting was being appropriately used in this manner to a certain extent. There were tentative Action Plans discussed regarding preferences in both instances, although strengths were less well addressed. There were also discussions about supports for community integration, but additional emphasis on developing a comprehensive and functional plan for community integration and awareness will be required. <u>Conclusion</u>: This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome	<u>Extent to which ISP specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet needs:</u> In a review of nine ISPs, including the two observed on-site, the IDTs did not consistently develop such a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs and overcome barriers to living in the most integrated setting. For example, for Individual #667, whose ISP annual meeting was held during this monitoring visit, the Monitoring Team observed a relatively robust discussion of the	Noncompliance

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	identified barriers to living in the most integrated setting appropriate to his/her needs;	individual's needs, preferences and strengths, but these were not adequately represented in the ISP. For example, discussion occurred related to the team's referral for community transition, including considerable detail regarding the type of setting and the community exploration process that would best fit his needs and preferences; important relationships in his life and how to sustain them; how important a sense of independence and control over his environment were to him; and, strategies to for positive behavior support. The final Action Plans submitted included, in addition to health care objectives, only the following: • With 3 verbal prompts while given the instruction, "--, brush your teeth," brushes teeth. • With one verbal prompt, make a purchase independently. This was to take place once a week. The instructions provided options that the setting could be the canteen or the in community, but there was no set expectation for performing this training in the community. • When asked 1 time, "Is your name --?" by nurse in order to identify self, -- will respond accordingly. • With 1 verbal prompt, "-- please pull the trash from the can", -- will comply with 80% completion rate in a consecutive 3 month span. • SLP and Programming will generate a SAP that will encourage communication when needing assistance. There was no Action Plan for community exploration, no Action Plan related to the individual's significant relationship and no Action Plan related to the individual's Positive Behavior Support Plan. Also refer to Provision F2a1. As described in Section S, the Monitoring Team was unable to evaluate, due to a failure of the Facility to provide adequate documentation, whether SAPs were generally individualized to the individual's needs. <u>Adequacy of processes for identification of and plans to overcome barriers</u>: In the section 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, barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. ISPs did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of eight (0%) recent ISPs reviewed	

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		evidenced proficiency in this regard. Also see Provision F1e above. Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. In such an approach, one would expect to see, for example, training in independent living skills to also have components that might include communication skills development, strategies for use of the skills in community settings, incorporation of positive behavior support techniques, and risk action plans. A program to improve dining skills might include techniques to encourage eating at a reasonable pace for both social and risk prevention purposes; use of a graphic menu to assist the individual to identify preferences, learn the names of foods and make choices; incorporation of reinforcement for safe dining behaviors and/or replacement behaviors; and might describe both formal and informal opportunities for community dining. Overall, adequate integration should be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, integrated health care plans, etc.,) in a measurable way into the ISPs through, for example, measurable objectives; • Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; • Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary There was some progress noted. For example, as reported in Provision J2, an ISP annual meeting for Individual #19 provided an example of integrated care between medical and non-medical professionals, DSPs, and included meaningful participation of the individual's sister who was his LAR. The topic under discussion was the possibility of the individual's possible transition to another residential home. There was an active discussion on how to provide the Individual with behavioral supports, if changes in residence were unavoidable; that discussion took his psychiatric symptoms into account. The Monitoring Team found that, although teams were making progress in their efforts to	Noncompliance

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		identify and incorporate individuals' preferences and work in a more integrated manner, none of the nine plans reviewed for this section (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Other examples found in this report that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • As reported in Provision O2, for only two of ten individuals (20%) were all recommendations by the PNMT addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. • As reported for Provision P2, therapy services were not consistently integrated into the ISP. • As reported for Provision P1, there was no discussion of in therapy assessments of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. <u>Conclusion</u>: This provision was found to be not in compliance. Overall, additional training was still 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 in a way that involves collaborative planning and recognition of the possible contributions of several disciplines to an area of need and/or preference.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Adequacy of methods for implementation:</u> As described in Section S, ISP programs were still generally not individualized to the individual's needs, nor did they contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions. As a result, SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person. Findings in Provisions S1 indicated that: • Three of the 14 SAPs reviewed (21%) reflected development based upon an individualized task analysis. • Five of the 14 SAPs reviewed (36%) reflected adequate objectives. • Five of the 14 SAPs reviewed (36%) reflected adequate operational definitions • Three of the 14 SAPs reviewed (21%) reflected an adequate description of teaching conditions • Only one of the 14 SAPs (7%) included an adequate number of trials. • Eight of the 14 SAPs in the sample (57%) included clear and specific cues that could serve as a discriminative stimulus • Three of the 14 SAPs in the sample (21%) included adequate instructions for staff. In many of the other reviewed SAPs, the instructions were often vague or	Noncompliance

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		included for only some aspects of the SAP. • Four of 14 SAPs in the sample (29%) included specific consequences for correct responses. • Nine of 14 SAPs in the sample (64%) included specific consequences for incorrect responses. • Six of the 14 SAPs in the sample (43%) included adequate maintenance and generalization strategies. <u>Adequacy of identification of time frames in action plans:</u> For none of the nine ISPs reviewed (0%) did action plans include adequate timeframes for completion. This assessment was based on a review that indicated timeframes were not individualized according to need and activity, but rather consisted for the most part of a standard (i.e. one year) completion date across the board. There were exceptions, but these were very limited. <u>Adequacy of identification of persons responsible in action plans:</u> The ISPs typically indicated by position who would be responsible for program implementation, documentation and data review. This did not appear to be sufficient to achieve the outcomes of ensuring program implementation was accomplished as required, however, as evidenced by the finding described above that methods of implementation were not adequately constructed by those identified as responsible for designing the specifics of the action plans. This was further evidenced by findings in Provision F2f which indicated that ISPs, including the completed Action Plans were not being put into place by those identified as responsible for ensuring plan development. <u>Conclusion</u>: 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	<u>Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings:</u> To establish compliance in this provision, IDTs must develop individualized action plans that effectively address the individual's assessed needs for services and supports and to promote increased independent functioning both at the Facility and in the community, as well as design interventions, strategies and supports that can be practically implemented both at the Facility and in community settings. As reported in Provision S1, a SAP would be practical and functional if it a) could be implemented in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed., Documentation did not reflect that a system was used to identify SAPs that were appropriate or practical for the locations in which training was to be conducted. In addition, none of the nine plans (0%) reviewed and/or observed effectively addressed the individual's full array of needs for services and supports in a	Noncompliance

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		manner that was practical and functional across settings. See also Provision F2a2. Conclusion: This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	<u>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:</u> 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. As reported in Provision S1, only four of the 14 SAPs in the sample (29%) included adequate documentation instructions. <u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u> For nine of the nine ISPs reviewed (100 %), the Action Plans defined the person(s) responsible for data collection. Similarly, for nine of the nine ISPs reviewed (100%), the Action Plans also clearly defined the person(s) responsible for data review. This did not appear to be sufficient to achieve the outcomes of ensuring program review was accomplished as required, however, as evidenced by the findings described in Provision F2d below. <u>Conclusion</u>: This provision was found to be not in compliance.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	<u>Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP:</u> This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Facility continued to implement initiatives toward coordination among staff, including the development and monitoring of the IRRF, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. The Monitoring Team commends the Facility for these initiatives to promote staff coordination in the development and monitoring of supports and services. Overall, however, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this report and this Section F. Examples of circumstances in which coordination of services could have been achieved, but was not, included: • As reported in Provision K5, for one individual, the psychiatrist described self-injurious slapping that was non-functional and driven in nature. A continuation of psychotropic medication was recommended, but the psychiatrist also requested further assessment by the behavior analyst. Following a functional	Noncompliance

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		assessment, the behavior analyst stated, "Problem behaviors are a function of socially mediated positive reinforcement and socially mediated negative reinforcement". Despite the contradiction between the psychiatric and behavioral assessments, no effort was documented to reconcile the differences and develop a coordinated treatment plan. • As reported in Provision T1b2, the Facility should have, but had not, created comprehensive coordinated plans for community living education and awareness for individuals. Such 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. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	<u>Extent to which ISP is accessible and comprehensible to staff:</u> The Facility continued to take and/or plan actions designed to promote accessibility and comprehensibility of the ISP. Examples included: • As reported in Provision K11, 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. A review of 10 records revealed that that the readability requirement was enforced by the peer review process. • The Facility also reported it was planning to develop two additional tools to toward improving these processes, including 1) a Readability Score Tool for the ISP as a whole and 2) a tool to interview staff responsible for implementing the ISP to determine if it is comprehensible to them. Overall, however, observations and review of program data indicated that the ISP did not appear to be comprehensible to the staff responsible for implementing it. For the nine ISPs reviewed, none (%) appeared to be written in a manner that would facilitate the ability of staff to comprehend and implement it appropriately. The ISP did not provide a picture of the services and supports the individual requires over the 24-hour day, nor was it written in a manner that facilitates understanding of who is supposed to do what, particularly direct support professionals, or how these activities would support an overall vision for the individual's life.	Noncompliance

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		There were still many instances in which staff could not describe supports contained in the ISP or did not implement them as called for in the ISP. Examples included: • As reported in Provision O4, per observations conducted by the Monitoring Team, three of 20 individuals' (15%) dining plans/PNMPs were implemented as written. • As reported in Provision R3, three of seven staff interviewed (42%) were knowledgeable of the individual and their communication related programs; Conclusion: This provision was found to be not in compliance.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, 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.	Monthly review of progress: The Facility required the QDDP to make an overall monthly review and evaluation of progress rather than a quarterly review. The Monitoring Team observed there was progress in the actual timely completion of the monthly reviews. There was also some progress noted in the substance of the recent monthly notes. Overall, however, the 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. For example: • As reported in Provision P2, direct PT/OT services were not consistently documented and did not provide comprehensive documentation regarding benefit of services as well discharge information sharing with the IDT. • As reported in Provision P2, for individuals with PNMPs or SAPs, for 0 of 22 individuals in Samples P1 and P2 (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. • As reported in Provision R4, only two of 10 individuals from Sample R1 (20%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. While the QDDP reviewed the supports, the information contained within the review was lacking detail regarding if the individual achieved progress and if the supports remained appropriate. The Pre-ISP meeting also provided an additional important vehicle to ensure the IDT was alerted to a lack of progress and/or significant changes, either of which would call for needed modifications to be assessed and implemented. This preparatory activity should serve as a complement to the monthly review process and ongoing IDT discussions that should be occurring. Conclusion: This provision was found to be not in compliance.	Noncompliance

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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.	Policy: DADS Policy 004.1: Individual Support Plan Process, dated 11/20/2012, Section IV states that. all staff responsible for the development and implementation of the ISPs receive competency-based training upon initial employment, as needed and on a refresher basis at least every 12 months thereafter. QDDPs receive training in the facilitation of ISP meetings upon initial employment with monitoring as needed. It also requires that all staff responsible for implementation of residents' ISPs must receive competency-based training on the implementation of the residents' plans for which they are responsible prior to performing employment duties without direct supervision, and staff must receive competency-based training when the plans are revised. It also required that professional staff/designee will be responsible for providing competency-based training to staff responsible for implementation of the ISP. Extent and adequacy of competency-based training for staff responsible for development of ISPs: Training sessions for the QDDPs and other IDT members responsible for development of ISPs included ongoing training provided by State Office staff and consultants on the implementation of the revised ISP process, including the Pre-ISP meeting. Examples of additional trainings that were conducted since January 1, 2013 included: • QDDP training was provided on "Increasing the Individual's Participation in Their Own ISP Meetings" on 6/17/13.] • QDDP training was held on person-centered planning techniques to support increasing individuals' participation. • The Facility provided training throughout January 2013 entitled "PSP Assessments-ISP Training." The purpose of the training was about how to strengthen the ISP process, including risks and goals and about Integrated Health Care Plans. All staff members in the following disciplines participated in the training: QDDP, Registered Nurses- Case Managers, Occupational Therapists, Physical Therapists, Speech-Language Pathologists, Physicians, Nurse Practitioner, Board Certified Behavior Analyst Psychologists and Dieticians. • A QDDP Skills Fair was held addressing Monthly Reviews and Change of Status. • Ongoing competency-based training on SAP development was being provided to the QDDPs and other responsible staff. In addition, as part of the QDDP training curriculum, the QDDP Coordinator was requesting a sample Functional Skills Assessment, Individual Support Plan summary, Skill Acquisition Plans, Monthly Reviews with data collection graphs for	Noncompliance

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		one individual per QDDP per quarter. The information requested was to be audited by the QDDP Coordinator using existing audit tools and findings were to be shared with each individual QDDP. To move in the direction of substantial compliance, the Facility should focus its efforts for the next six months on the following: • 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, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> The Facility continued to work towards other competency-based training for staff responsible for implementation of ISPs. Examples included: • As reported in Provision M4, substantial compliance was found related to competency training for nursing staff. • As reported in Provision O5, a process was currently being developed by DSSLC that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. • As reported in Provision R3, DSSLC did develop comprehensive competency based training regarding communication services. Staff responsible for training other staff also did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' plans prior to training others. Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. Examples included: • As reported in Provision O5, there was no evidence that staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. • As reported in Provision R3, there was no evidence that staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' communication prior to training other staff on the AAC devices.	

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		• As reported in Provision K12, substantial limitations were noted in the ability of the Facility to ensure that all direct contact staff and their supervisors were competent concerning the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans. This finding was also influenced by the lack of active treatment and engagement observed and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. The Monitoring Team conducted observations in a variety of settings across the DSSLC campus with the following findings: • As documented in Provision S1 of this report, based upon the observations conducted during the current site visit, it was evident that overall functional engagement had decreased from 59% to 41% of individuals. In some residences, the lack of functional engagement appeared to place individuals at risk of personal harm. Staff were not observed to interrupt undesired behaviors or organize structured activities. • As reported in Provision O4, staff were not consistently knowledgeable of the individuals' PNMPs; knowledge of staff had continued to improve but was not yet adequate to ensure correct implementation. Staff did not appear to be aware that they were not implementing the plans and were unaware of the dangers that are being placed on the individuals due to the plans not being implemented as written. Zero of 7 individuals' positioning plans (O.5) (0%) were implemented as written. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	<u>Extent to which ISPs are developed within 30 days of admission:</u> The Facility reported 15 admissions in the past six months. The Monitoring Team requested all ISP information for five individuals newly admitted to DSSLC within the past six months, representing a sample of 33%. For five of the five (100%), the 30-day ISP meeting was completed within 30 days. For the most part, the assessments for these ISPs were also completed within the thirty day timeframe, although vocational assessments were significantly delayed for two of the five individuals. For one of the five, the ISP was not complete in that the Action Plans were blank; however, four SAPs were available for review. <u>Extent to which ISPs are revised annually and as needed:</u> In assessing this Provision the Monitoring Team relied primarily on a list provided by the Facility that included each individual in residence, the date of their most recent ISP meeting and the date of the previous ISP meeting. This list was dated Thursday, June 06,	Noncompliance

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		2013. The list indicated 17 ISPs were completed more than 365 days following the previous one. Of these 17, the Facility provided clarification that eight had erroneous data entered and were in fact completed within 365 days. Of the remaining nine, two were reported to be late due to a change in QDDP assignment, two were postponed due to guardian request and one delayed due to the individual's hospitalization. From this list the Monitoring Team was able to determine that only one of 278 (.03%) was listed as having been held more than 365 days past the date of the previous ISP. The Facility was to be commended for this improvement. <u>Extent to which ISPs are put into effect within 30 days of preparation:</u> Although the document request also asked the list include the date the most recent ISP was put into effect, this information was not provided. The Monitoring Team reviewed a sample of twelve ISPs, including the seven that represented one from each residence and the five new admissions described above. There were many instances in which it was clear the ISPs, or portions thereof, had not been implemented for several months past the implementation date listed in the ISP. This included implementation of SAPs, referrals and follow-up actions assigned to various IDT members. <u>Conclusion:</u> This provision was found to be not in compliance due to the failure to implement ISPs to implement 30 day and 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.	The Monitoring Team reviewed the Denton State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated May 28, 2013 and interviewed the Quality Assurance Director regarding the status of quality assurance processes for identification and remediation of problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section. The Facility QA Plan indicated it included a number of monitoring devices related to the Provisions of the section, including • Department and QA audits with the Section F monitoring tool • Analyzing trends in data • Auditing active treatment • Auditing composition and quality of ISPs, SAPs, etc. • Conducting observations of staff implementation of plans • Audits on timeliness of assessments • Audits of scheduling of annual ISP meetings • Audits of assessment quality • Audits in the homes to determine if staff are correctly implementing plans The Facility was also planning to develop a system to audit the ISP development process, including. PSIs completed, ISP Preparation Meetings, QDDP ISP preparation activities, etc.	Noncompliance

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		Conclusion: This provision was found to be not in compliance. The Facility was to be commended for its efforts toward developing a comprehensive quality assurance system for this Section. These processes were continuing to develop; based on the outcomes at this time, it was not yet clear the processes were effective in terms of identifying and remediating issues that would ensure ISPs are developed and implemented consistent with the provisions of this section.	

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plans 6/21/13 3. Presentation Book for Section G 4. Provision Action Information 5. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 6. DADS Policy 009.2 Medical Care 5/15/13 7. DSSLC Policy CMGMT 03 Integration of Clinical Services 5/31/13 8. DSSLC Policy MED-01 Medical Care 8/17/10 9. DSSLC Policy Medical-01 Medical Care Exhibit G—Process for Consultations 7/1/13 10. DSSLC Policy CMGMT 14 At Risk System Addendum H 2/1/13 11. Consultation Report blank form 11/8/12 12. Medical consultation reports for 10 individuals (Individuals #170, #242, #335, #367, #416, #423, #492, #581, #637, and #697). 13. DSSLC Integrated Morning Report (IMR) Protocol 14. Minutes of Integrated Morning Report meetings of 4/1/13, 4/19/13, 4/22/13, 4/23/13, 4/24/13, 4/25/13, 5/10/13, 5/13/13, 5/22/13, 6/6/13, and 7/24/13, including attendee sign-in sheet, attached notes about individuals, infirmary census reports of individuals, daily residence summary, hospital report, and other attachments 15. Example of one IMR showing follow up of referral to IDT, for Individual #411 16. Evidence of Integration Meeting Attendance G1 Data June 2013 17. Integration of Personal Support Planning: Overview training materials 18. Health Services Compliance Coordinator (HSCC) audit form for medical providers blank and completed form for an audit of three medical providers 19. Graph of HSCC audits for Provision G2, October 2012-June 2013 20. Consultation Reports and related documents for Individuals #216 and #461 documenting referral of consultation recommendations to IDT **People Interviewed:** 1. Joint interview of Nancy Condon, Facility Director, Steven Kubala M.D., Medical Director, Donna Groves, Director of Habilitation Services, and Dianne Tompkins, Health Status Compliance Coordinator (HSCC) **Meeting Attended/Observations:** 1. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 7/23/14 and 7/24/13 2. ISP Annual Planning Meeting for Individual #626 3. ISP Preparation Meeting for Individual #519 4. Integrated Morning Report meeting of 7/24/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G, dated 7/8/13. 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. For Section G, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment were not named. One included a question about whether IDT discussion included integrated services. A second was for observation of signs of integration. A third was the Health Services Compliance Coordinator (HSCC) review of Summer 2013. o The self-assessment did not provide information to allow the Monitoring Team to determine of they included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. For example, one question in an audit asked whether the IDT discussion included integrated services. Because that information was from review of ISPs, it was unclear what "discussion" was referenced or the criteria for rating a response. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as review of ISP meeting attendance, review of ISPs, observation at clinical meetings, review of consult audits, and review of the relevant question on the external and internal medical provider audits. The self-assessment also provided data on several clinical indicators of system status of healthcare but did not indicate relevance to the requirements of this Section. For observation of meetings, the self-assessment did not indicate how the observer determined there were signs of integration. o The Self-Assessment identified the sample(s) sizes for ISP meeting attendance, review of ISPs, and healthcare audit data, including the number of individuals or records reviewed in comparison with the number of individuals/records in the overall population, but did not identify the sample size for clinical meetings observed. This sample sizes reported were adequate to consider them representative samples. o The Monitoring Team did not review the monitoring/audit tools to determine whether they had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o Except for the Health Services Compliance Coordinator audits, the self-assessment did not identify which staff/positions were responsible for completing the audit tools; therefore, the Monitoring Team could not determine whether the staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. o The self-assessment reported inter-rater reliability only for the external and internal provider audits regarding the relevant question. For that question, adequate inter-rater reliability had been established. ▪ Did not use other relevant data sources and/or key indicators/outcome. For Provision G1, summary statements were provided about trended data on healthcare clinical indicators (actual

	data were provided for some but not all, and some had comparison to prior period—the self-assessment also noted the evidence books would contain graphs and additional information) but there was no indication of what requirement(s) this review of trended data was meant to assess. ▪ The Facility rated itself as being in compliance with Provision G2. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with neither sub-section. The Facility audits found an increasing trend in compliance, with a range from 59.2% in February 2013 to 100% in June 2013 and concluded this was sufficient to rate substantial compliance, the Monitoring Team (consistent with the self-assessment data) Integrated Progress Notes were completed for 83% of consultations (75% within five days). Furthermore, the consultation report forms did not report referral to IDTs, although there was a process in place to make referrals. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve continued compliance. • Most actions were reported as or in process" and had completion dates of 7/31/13. • The Facility should review this report to identify areas in need of further action and should develop action plans to achieve substantial compliance.
	Summary of Monitor's Assessment: 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, and there was evidence of integrated clinical services both through committees that reviewed care for individuals and through routine involvement of different disciplines in specific areas of services. Nevertheless, integrating planning and services across disciplines remained a challenge. The facility policy on Integration of Clinical Services had been substantively revised to address assessment timeliness and quality, use of clinical indicators, and elements of data to be included in monitoring of treatments, interventions, and health status of individuals. This report provides several examples of collaborative and integrated planning and case formulation. In particular, the Integrated Morning Report and the Physical and Nutritional Management Team provided opportunities to ensure collaboration as well as notice to the interdisciplinary teams (IDTs) for individuals. At the same time, there were examples of lack of integrated planning or of lack of documentation that such planning occurred. There were also examples in which it appeared that clinicians from more than one discipline may have collaborated, but where the services and supports were not integrated into 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 that involve integrated planning become part of the IDT process and are integrated into ISPs. The Facility had appropriate processes in place to facilitate documentation of review of recommendations from non-facility clinicians, to make referrals to the IDT when appropriate (through both documentation and the Integrated Morning Report), and to communicate through the IPN process. However,

	improvements must be made in carrying out these processes, as consultation forms were not always completed, and documentation of referral to the IDT, as appropriate, was not present on consultation forms.

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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. Improvements had occurred through the Integrated Morning Report process, the Physical and Nutritional Management Team (PNMT) and Committee (PNMC), psychiatric medication reviews, and, to a degree, the ISP process. Processes other than committees and IDT meetings also contributed, such as the collaboration of Speech and Language Pathologists (SLPs) and psychologists on the development and implementation of behavioral supports and alternative and augmentative communication systems (AAC). Nevertheless, integrating planning and services across disciplines remained a challenge, and this provision was not yet in compliance. <u>Policy</u> DSSLC Policy CMGMT 03 Integration of Clinical Services had been revised. This purpose of this policy was to "provide integrated clinical services… to ensure that individuals receive the clinical services they need. Treatments and interventions shall be modified in response to clinical indicators." One revision was the addition to the purpose of modifying treatments and interventions in response to clinical indicators. This important revision is also relevant to requirements of Section H and several other sections of the Settlement Agreement. Revisions to this policy were substantive. The prior version consisted mostly of a listing of meetings that involved multiple disciplines and descriptions of those meetings, their membership, purpose, and frequency of meetings. The newly revised policy establishes requirements for assessments by clinical disciplines, both routine and in response to specific events. It requires clinical departments to monitor a number of elements, including timeliness, response to change in status, and quality indicators. The policy also requires clinicians to be responsible for accurate and complete diagnosis coding. It requires Psychiatry and Psychology to formulate diagnoses and plans as a team. The policy also provides examples of guidelines used to govern treatments and interventions. In addition, it lists the elements of data to be included in monitoring of treatments, interventions, and health status of individuals.	Noncompliance

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		The policy includes sections on the use of clinical indicators, on monitoring health status of individuals, and on modifying treatments and interventions in response to clinical indicators. These will be covered more fully in Section H. Regarding integration of clinical services, this section specifically points out that processes that constitute health care include contributions "by direct support staff, residents and their families." It also points out the role of the QA/QI Council as an interdisciplinary team that oversees matters including health status of individuals served. Carried over from the prior draft is a description of integrated committees and shared activities. <u>Integrated Morning Report</u> The Monitoring Team reviewed minutes of IMR meetings for each weekday and for a meeting observed during the compliance visit. The Monitoring Team also observed an IMR meeting. A positive finding was the continued evolution of the IMR. The format of the morning medical provider meeting (now called the Integrated Morning Report) had been revised to include a standard agenda and schedule of presentations. There was a specified agenda for daily meetings, with specific weekly reports scheduled during the week (schedule includes presentations from PNMT and habilitation Tuesday, community placement update Wednesday, and dental report and missed consult appointments on Thursday). The Medical Director or a designated person will take notes about change of status, follow-up needed due to abnormal findings or another issue. Minutes are now kept on the Share Drive so they are accessible to all participants. The Facility stated that all change of status is referred to IDT; the QDDP Coordinator or an assigned backup is to attend each IMR. The HSCC is to follow up till the IDT meets and to inform the IMR if there is a problem. Referrals to specialists are to be brought up at each IMR till resolved (for example, till the procedures the specialist recommended have occurred). Other participants who attended regularly as indicated by minutes included primary care providers, the Director of Behavioral Services or other behavioral services staff, the Infection Preventionist, hospital nurse liaisons, the skin integrity nurse, the infirmary RN, the HSCC, the RN Case Manager Supervisor and RN Case Managers, the PNMT nurse, and pharmacy representative. On at least a weekly basis (usually Wednesday), the Facility Director and Community and Family Relations director participated. Documentation typically included a Morning Meeting agenda and standard minutes document that included the on-call log report, places for topics that were scheduled only	

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		periodically, and a place for additional information discussed. The On-Call Log Report section had a column for "Referral, as needed"; this column had a list of possible follow-up actions (such as "Change of Status IDT," "Nursing,", "Fam Contact," along with NA and Other) and a column that identified whether follow up is not required, is required in AM meeting, and notes. Columns for follow up were also in the sections for topics that did not occur daily, such as the Appointment/Consult Report and Systemic Issues. A signature sheet was attached, as were a number of other documents. These included: • Handwritten notes that described issues and actions for individuals • An infirmary census that listed individuals, diagnoses and provider comments, and actions needed • A Daily Residence Summary that gave status of leaves, including hospitalizations • A Hospital Report that included status of individuals and actions needed The Monitoring Team attended the IMRs of 7/23/13 and 7/24/13. The meeting was conducted efficiently and consistent with the meeting format. Observation of the integrated morning report indicated a robust process whereby clinical issues that occurred during the preceding night, current hospital admissions, and significant clinical events, were discussed through an interdisciplinary and integrated approach. Attendance included a pharmacist, medical director, unit medical providers, unit and clinic nurses, physical and occupational therapist, psychologist, psychiatrist, and QDDP coordinator. Documentation for the 7/24/13 meeting on the On-Call Log Report had follow-up notes for each individual; for three individuals, "Change of Status IDT" was marked. For Systemic Issues (discussed because this was scheduled for Wednesdays), one item was referred to pharmacy (this was a follow up to review already assigned to pharmacy) and one to PNMC; the other three had action plans but did not list a "Referred to." There was not a clear way to follow all these different documents to a set of actions to be taken and follow up to be done. For example, on 7/24/13, Individual #218 was identified on the Daily Residence Summary as "sliding in bed." There was discussion at the IMR about this, with an appropriate determination that Habilitation Services would check the individual and follow up as needed. However, this action was not listed anywhere on the minutes. In addition, the Infirmary Census report listed (among 21 individuals) five individuals who were transferred or triaged back to home, seven individuals being assessed or treated for possible aspiration or aspiration pneumonia, and one individual with bowel obstruction. None of these indicated an action needed due to change of status or referral to the IDT (although a great deal of other information was found on the form). The Facility should consider developing a process to draw together minutes of all discussion so that any actions determined to be needed would be clearly listed.	

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		Also, as reported in Provision L1, review of the Morning Meeting Log form, for the week of March 4, 2013, indicated that the PCP on-Call Log report, was not fully completed, as there was no documentation for the sections: referrals, follow-up, and closure. The Monitoring Team requested an example of minutes that documented referral from the IMR to the IDT. In response, the Facility provided minutes of 4/16/13, 4/19/13, 4/22/13, 4/23/13, 4/24/13, and 4/25/13, and an Individual Support Plan Addendum (ISPA) of 4/24/13. The IMR minutes showed frequent follow-up while awaiting an IDT meeting. The issue to be reviewed, according to the IMR minutes, was "SIB better 2:1." The IMR minutes of 4/25/13 documented the IDT met and the issue was closed. The ISPA documented a thorough discussion that included one statement that behavioral issues did not require 2:1 staff (but did not provide any information on whether SIB was better) but focused more on whether 2:1 staff was required during ambulation due to weight and unsteady gait. Thus, the issue of SIB that led to the referral from the IMR to the IDT was addressed, if briefly, and the referral led to a discussion about a different purpose for the increased level of supervision, and a plan to begin reduction of increased supervision. The Facility had implemented and continued to improve what appeared to be an integrated and effective process. To improve it further, the Facility should improve documentation to ensure all decisions and actions to be taken are clearly identified. <u>Other Integrated Committees and Workgroups</u> Physical Nutritional Management Team (PNMT) and Physical Nutritional Management Committee (PNMC): As described in Provision O1, 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. In ten of the ten individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT or discussion by the PNMT within five working days of the ISPA meeting and/or PNM incident. In addition to referrals, another method in which the PNMT was made aware of changes in status was through participation by the PNMT members in the IRT, IMRT and Integrated Morning Report meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not	

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		already done so. 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. Polypharmacy Review Committee: 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; meetings were attended by 20 individuals or more. <u>Examples of Integrated Planning</u> Through observations, interviews, and reviews of documentation, the Monitoring Team identified additional examples of both integration of clinical services. A few examples follow: • Integration of psychiatric services: The Monitoring Team noted progress, albeit limited, in the area of integrated care. The progress was evident in some improvements in PBSP integration, per the above and per information discussed under Provision J3. Progress was also evident in improvements in ISP presentation of psychiatric information, per the above. The Monitoring Team agreed with the Facility Self-Assessment that there is need for further improvement in PBSPs, in psychiatric symptom tracking, and inclusion on meaningful psychiatric information in ISP documents. These are needed to integrate pharmacological treatments with behavioral and other interventions though combined assessment and case formulation. As reported in Provision J12, Psychiatric Medication Review (PMR) meetings also provided examples on collaboration across disciplines. The Monitoring Team attended PMRs on 07/23/13 for Individuals #204 and #704 and observed how information about side effects was discussed by IDT members. Information about side effect screening was presented by the nurse during the part of the discussion that was dedicated to objective medical data and review of that data. That section also included information from the pharmacy provided via the QDRRs. Information presented included laboratory data, drug/drug interactions, and pharmacy recommendations for clinical information that were derived from that data. The discussion for Individual #204 included a detailed discussion between the psychiatrist and nurse about current and past side effects of medication, and there was an active discussion about appropriate management given the individual's diagnosis of tardive dyskinesia but currently low ratings on the DISCUS. The quarterly PMR review of Individual #704 also contained a review of MOSES related to the Individual's treatment with Aricept.	

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		The Monitoring Team found that the discussion identified the relevant risks and benefits and that sufficient and up to date information had been presented so as to make the evaluation meaningful and substantive. • One example was provided of integration of counseling and skill acquisition planning. Individual #213 had been participating in counseling. When the individual and IDT determined the success criteria for counseling had been met and it was time to terminate counseling, the clinician recommended procedures for the IDT to continue the training that had been provided during counseling. The QDDP prepared a Skill Acquisition Plan that included the recommended procedures. This had not yet been implemented but was a positive example of coordinating plans so that gains made during counseling might be maintained. • Provision M1 reports on Individual #553. Integrated care planning and implementation was effective in reducing instances of UTIs. • As reported in Provision M1, the Hospital Liaison Nurses 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. Furthermore, the Hospital Liaison Nurse requested assistance from the PNMT OT and PNMT RN to review the care of Individual #86 at a hospital; the two disciplines jointly developed recommendations for improvement and worked with the hospital to have the recommendations implemented. • Also reported in Provision M1, the Hospital Liaison Nurse arranged informal in-service training with DRMC ENDO Lab Nurse, of which several habilitation and PNMT staff attended. This information was provided to relevant IDT members to increase awareness of managing/monitoring the external bolsters to prevent movement and leaking. This demonstrated her responsibility to provide coordination/integration of services with other disciplines and IDTs. • The Speech Department worked with the Chaplain to integrate communication boards and devices into services on campus. One use has been to provide individuals the opportunity to request certain hymns. • SLPs also worked with psychologists on the development and implementation of behavioral supports and alternative and augmentative communication systems (AAC). • There was significant integration of services and supports across relevant disciplines and the IDTs in the management of diabetes. <u>Examples of Need for Improved Integration</u> The Monitoring Team also identified opportunities for greater integration, such as the	

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		following: • OT/PT recommended adaptive equipment for Individual #565, including use of a Parker tub, but this was not integrated into the PNMP or IHCP. • Individual #461 had a several recent fractures, including fractures of the leg, ankle, and foot. The IRRF indicated that the Individual might be experiencing pain, and was provided Tylenol. Also reported by an addendum to the ISP was that the individual was experiencing self injurious behavior. Despite suspected pain, increase in self injurious behavior, high risk for falls and related injury, and recent fractures, there was no indication that a robust assessment for possible occult fractures, such as by assessing the individual with scout films, bone scan, or even a comprehensive physical examination. There was no indication that the presence of self-injurious behavior was considered in reviewing the potential that additional fractures might be a sign of response to pain or of additional fractures. • PNMT recommendations were not consistently addressed or integrated in IRRFs and IHCPs. • As reported in Provision M3, Skin Integrity Acute Care Plans did not consistently provide evidence of integration of care with other relevant disciplines. <u>Integration of Services in ISPs and Programs</u> The Facility provided training on the ISP process. Review of training materials showed this included the Integrated Health Care Plan (IHCP), including Action Plan considerations for medium and high risk that listed possible actions; for several risks, the possible actions would typically involve a variety of clinicians and disciplines in planning and implementation. For integrated planning to occur, clinicians must participate in interdisciplinary meetings, such as the ISP annual planning session. The Facility provided information from a sample of 63 ISP sign-in sheets. Of these: • Sixty-three (100%) had a QDDP present. • Sixty-three (100%) had a representative from Nursing. • Sixty-two (98%) had a representative from Habilitation Therapy. • Sixty-two (98%) had a representative from Vocational/Day Programming. • Sixty-one (97%) had a Primary Care Provider present. • Thirty of the 33 individuals who receive services from psychiatry (91%) had a representative from Psychiatry. • Fifty-seven (91%) had a representative from Direct Support. • Thirty-seven (59%) had a representative from Psychology. It should be noted that not all individuals have behavioral issues that require PBSPs or other psychological treatment and may not be required at each meeting (although	

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		psychologists may be able to provide suggestions that support other interventions such as skill acquisition programs). • Twenty-seven (43%) had a representative from dietary/nutrition services. • Zero (0%) had a representative from Dental Services. As reported in Provision F1b, attendance at a sample of ISP annual planning meetings as determined by the Monitoring Team from a review of the signature sheets for all eight ISPs held during the week of the compliance visit indicated similar levels of attendance for the IDT member disciplines reviewed, except that psychology attendance had improved. However, as reported in Provision F1b, for ISP Preparation meetings held during the monitoring visit, there was some concern that the commendable intent of the process was undermined by a lack of IDT participation. The number of IDT members participating ranged from three, for two of the meetings, to a high of six.	
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</u> DADS Policy 009.2 was implemented 5/15/13. This policy describes the responsibility of the attending primary care physician (PCP) to write initial consultation referrals, and the required content of the referrals. It provides a timeline of five working days for response to routine medical/surgical consultation recommendations. It identifies IDT responsibilities to document implementation of recommendations. DSSLC Policy MED-01 Medical Care includes requirements for consultations. This policy requires the consultation request to include, at a minimum, the problem or question to be addressed, pertinent past medical history, pertinent laboratory and other data, current diagnoses, and medications. The Facility recently a Process for Consultations as Exhibit G for the Medical 01 Medical Care policy. This procedure requires that the "PCP writes the order for a consult request and includes the reason for the request, whether it is an evaluation or follow-up visit, and the history of the individual including treatment." Between the policy and the process exhibit, the requirements for the order are consistent with the requirements of DADS policy. The request then goes to staff who schedule the appointments and requires the appointment information to be placed on computer for access to a wide range of staff who may need to know. A separate list provides information about possible need for sedation. The process also identifies responsibilities for preparing the consult packet, arranging transportation, providing the referral packet to the consultant and returning the completed consultation form, documenting recommendations and follow-up orders, involving the IDT in follow-up, and tracking appointments that occurred or were missed.	Noncompliance

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		Procedures and Forms The Consultation Report form had been revised 11/8/12. This form included on the first page the reason for the consultation request (including whether it was for an acute, preventive, or routine purpose) 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. Review of Consultations by Facility Clinicians The Monitoring Team reviewed a sample of 12 medical consultation reports for 10 individuals (Individuals #170, #242, #335, #367, #416, #423, #492, #581, #637, and #697). Nine of 12 consultation forms (75%) included documentation of review by the facility clinician. There was no documentation on consultation forms for Individual #335 (3/25/13) and Individual #423 (1/28/13). Documentation on the consultation form for Individual #581 (5/2/13) was incomplete. For 10 of 12 consultations (83%), an IPN was completed. Of these 12, nine (75%) were completed within five working days following receipt of the consultant report. For 10 of 12 (83%), there was documentation that the facility clinician accepted the recommendation of the consultant. This was not the case for Individual #335 (3/25/13) and Individual #433 (1/28/13). For 0 of 12 medical consultations (0%) there was documentation on the consultation form of referral to the IDT. However, the Facility had a process in place to filter consultations through the Integrated Morning Report meeting. Although review of the sample did not find documentation of referral to the IDT, the Facility provided two examples with documentation that followed from the consultation report through IDT involvement, for Individuals #216 and #461, in response to a request from the Monitoring Team for a consultation report showing referral of recommendations to the IDT. • The documents for Individual #216 included a dysphagia evaluation of 4/24/13, and a dysphagia consultation report that included a radiology report of 4/24/13 with results of a modified barium swallow study (MBSS) and recommendations from the evaluation, and a Personal Support Plan Addendum (PSPA) dated	

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		5/2/13. The ISPA stated the "IDT met on 04/05/2013 to discuss the results of (the individual's) swallow study." It then described the outcomes of a study and stated "The RNCM will f/u with the PCP on his recommendations for swallow study (team will await the doctor's order per swallow study)." The PSPA did not indicate the IDT had received PCP recommendations yet. Apparently, this was a second meeting about the MBSS (since there was reference to a meeting 4/5/13), but it was unclear whether there was a second MBSS. The Consultation Report was not provided. The documents showed interaction between the IDT and PCP but did not show referral of recommendations for IDT review. • The documents for Individual #461 included a Consultation Report with PCP review date of 6/27/13 and documentation of referral to the IDT ("Will notify {QDDP RNCM Psych} of tapering to D/C"), an IPN of 6/27/13 by the PCP reporting on the consultation and plan, and an Individual Support Plan Addendum (ISPA) of 7/22/13 to discuss progress since the medication was tapered. The ISPA reported on reductions in problematic behaviors since taper (an integrated review, since the medication was for seizures). The IDT decision for further monitoring was described. Although this was a good example of IDT involvement, the IDT meeting was nearly a month following the PCP review of the consultant's recommendation. Thus, although this example did not show that the IDT was involved in the decision to taper the antiseizure medication it was an excellent example that showed integrated review following a medication change as well as integration into existing supports and services. The Facility had appropriate processes in place to facilitate documentation of review of recommendations from non-facility clinicians, to make referrals to the IDT when appropriate, and to communicate through the IPN process. However, improvements must be made in carrying out these processes.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plans 6/21/13 3. Presentation Book for Section H 4. Provision Action Information 5. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 6. DADS Policy 009.2 Medical Care 5/15/13 7. DSSLC Policy MED-01 Medical Care 8/17/10, including Exhibit H Medical Quality Assurance 7/1/13 8. DSSLC Policy CMGMT 03 Integration of Clinical Services 5/31/13 9. DSSLC Integrated Morning Report (IMR) Protocol 10. Minutes of Integrated Morning Report meetings of 4/1/13, 4/19/13, 4/22/13, 4/23/13, 4/24/13, 4/25/13, 5/10/13, 5/13/13, 5/22/13, 6/6/13, and 7/24/13, including attendee sign-in sheet, attached notes about individuals, infirmary census reports of individuals, daily residence summary, hospital report, and other attachments 11. Health Services Compliance Coordinator (HSCC) audit form for medical providers blank and completed form for an audit of three medical providers 12. Integrated Health Care Plan Assistance a. Constipation b. Osteoarthritis/Degenerative Joint Disease c. Metabolic Syndrome d. Urinary Tract Infection e. Tuberous Sclerosis 13. Osteoporosis Guidelines for the PCP 14. QA/QI Council Data Review Meeting documents, including HSCC audit graphs for Provisions H1, H2, and H4 and graphs of key indicators 15. DSSLC Quality Assurance (QA) Plan Key/Clinical Indicators 16. DSSLC Reference Material Index 17. Physical and Nutritional Management Committee (PNMC) Minutes of 5/16/13 and 5/23/13 18. PNMC Clinical Indicators Actions and Results Review October 2012-June 2013 including actions through July 2013 19. Corrective Action Plan (CAP) undated, with CAPs due date of 3/22/13 20. Active Record for Individual #694 21. ISPs for Individuals #42, #288, #317, #490, #567, #772, #788, #19, #65, #231, #441, #626, #667, and #697 **People Interviewed:** 1. Joint interview of Nancy Condon, Facility Director, Steven Kubala M.D., Medical Director, Donna Groves, Director of Habilitation Services, and Dianne Tompkins, Health Status Compliance Coordinator (HSCC) **Meeting Attended/Observations:**

	1. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 7/24/13 2. ISP Annual Planning Meeting for Individual #626 3. ISP Preparation Meeting for Individual #519
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section H, dated 7/8/13. 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. For Section H, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The Section I monitoring tool information regarding assessments completed in response to changes in status. Because this related to Section H, it was unclear as to the relevance, or whether this was a typographical error. ▪ Health Services Compliance Coordinator (HSCC) audit of records. ▪ External and internal medical provider audits. o These monitoring/audit tools included indicators to allow the Facility to determine compliance with some requirements of the Settlement Agreement. Along with other information, these tools provided valuable information adequate to determine compliance. The Facility is encouraged to review the Monitoring Team's report to identify any additional indicators that are relevant to making compliance determinations. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. This sample sizes were adequate to consider them representative samples; however, although the external medical audit sample met the requirements of DADS policy, the Monitoring Team is concerned that it may not be adequately representative. o The Monitoring Team did not review the monitoring/audit tools to determine whether they had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o Except for the Health Services Compliance Coordinator audits, the self-assessment did not identify which staff/positions were responsible for completing the audit tools; therefore, the Monitoring Team could not determine whether the staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. o Inter-rater reliability was not reported for any of the monitoring tools/audits or data provided. o ISP monitoring (unnamed monitoring tool) ▪ Used other relevant data sources and/or key indicators/outcome measures. These included: o Timeliness of annual ISP assessments for several clinical disciplines, reported as

	percentages by discipline each month o Timeliness of scheduled assessments including quarterly assessments for physicians, reported as a percentage by month o Timeliness of implementation of PBSPs, reported as percentage current o Number and percent of individuals who had received a PNMT Nurse Post Hospital Assessment and were reviewed by the PNMT o Percent of correct listings of diagnoses on Active Problems Lists o Trended data on several clinical indicators o QA staff review of a sample of individual records to determine if plans to mitigate risks included clinical indicators as applicable, reported as a percentage of records including clinical indicators and by number yes/no ▪ The Facility for the most part presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators for many measures but not for all. For example, data on timeliness of scheduled assessments involved a specific measure presented in a clear table. For trended data presented at QA/QI and/or PNMC, some specific data were provided, but some summaries of status were presented in narrative. o Did not consistently report the quality as well as presence of items. For example, the self-assessment reported on the timeliness of assessments but not on whether they detected individuals' needs accurately or were comprehensive. However, the self-assessment for Provision J6 was referenced specifically in regards to the need for improvement in quality of documentation. Another example was that timeliness, but not quality, of PBSPs was reported. ▪ The Facility rated itself as being in compliance with no provisions of Section H. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified a few areas of need/improvement. However, the statements of area of need/improvement were brief and general. For these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve continued compliance. • Actions were reported as or in process. • Although the actions listed should move the Facility closer to substantial compliance, many required more clarity as to what would actually be done and what would constitute being complete. For example, the action to "Use timeliness of implementation following change of status data for ongoing change including during quarterly QAQI meetings" does not make clear what would be done to "use timeliness" or how the Facility would know this has been accomplished effectively. The action "Hold PCPs accountable for provision of correct diagnoses" does not describe either a process to be implemented or how the Facility will know

	this action is completed. • The Facility should review this report to identify areas in need of further action and should develop action plans to achieve substantial compliance.
	Summary of Monitor's Assessment: As noted in the report from the last compliance visit, 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. Continued improvement had occurred, particularly in addressing system wide improvements. Timeliness of assessments had continued to improve. When timeliness began to slip, the Facility identified that and addressed it effectively. Comprehensiveness of assessments, while not yet adequate to achieve compliance, had improved significantly in several clinical disciplines. The Facility was now routinely using clinical indicators to assess status of healthcare and identify areas of need for systemic actions. Many of these indicators were fully integrated into the key indicators used by the Facility for quality review. In addition, the PNMC reviews and acts on a number of these indicators. At an individual level, it was still not always clear that indicators were well-defined, and that modification of treatments and interventions reflected the use of the indicators in identifying when changes in status required them. Furthermore, it was unclear that monitoring was done consistently and made full use of the information from clinical indicators. Regarding policy development and implementation, the Facility made changes to require clinical disciplines to monitor a number of elements relative to assessments, including timeliness, response to change in status, and quality indicators. DADS needs to complete revision of a policy on minimum common elements of clinical care and needs to ensure the policy addresses all areas of clinical care.

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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'	<u>Policy</u> DADS Policy 004.1 continued the requirement that IDT members complete required assessments and place them in the shared drive for IDT review no later than 10 working days before the annual ISP meeting. DSSLC Policy 004.1 Individual Support Plan Process requires IDT members to complete recommended and required assessments and place them in the share drive for IDT review no later than 10 working days before the annual ISP meeting.	Noncompliance

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	needs.	DSSLC Policy CMGMT 03 Integration of Clinical Services had been revised substantively. Among other additions, this newly revised policy establishes requirements for assessments by clinical disciplines, both routine and in response to specific events. It requires clinical departments to monitor a number of elements, including timeliness, response to change in status, and quality indicators. <u>Extent to which assessments are conducted routinely</u> The Facility provided in the Self-Assessment data on timeliness of assessments. For Provision F1, the Facility provided a table listing 12 assessments (10 clinical disciplines plus the Functional Skills Assessment and the Self-administration of Medication assessment) and provided monthly data on "being placed in the shared folder 10 days prior to the ISP meeting" for each from October 2012 through May 2013. For Provision H1, the Facility provided a table of five clinical disciplines plus the Functional Skills Assessment (FSA). Because the data were consistent, this report discusses the table for Provision F1. That table reported averages across the period ranging from 63% for Speech and 64% for Medical to 95% for Audiology and 97% for Pharmacy. The sixth and seventh highest (the median) were 84% for OT/PT and 82% for Nursing. Three disciplines (Speech, Medical, and "Psych") and the FSA were timely less than 70% of the instances. Graphs of assessment compliance by unit and discipline from December 2012 through May 2013 were provided as part of the QA/QI Council Data Analysis Report of 6/18/13. It was positive that the Facility was tracking this information routinely and was reviewing information for at least a six-month period to identify trends. Based on review of the graphs, timeliness ranged from less than 50% (only in January 2013 for two units) to nearly 90% found more recently for three units. The trend was a clear increase in timeliness for six of seven units (86%) with a stable trend around 80% for the other unit. In comparison with information in the report from the last compliance visit, which reported that six of seven living units had more than 80% of assessments provided timely in September 2012, it appeared there had been some decline by December 2012, when four of seven units reported timeliness greater than 80%, and then continuing decline in January 2013, with recovery beginning in February 2013 and six of seven units again reporting 80% or greater timeliness in April and May 2013. By discipline, Pharmacy was consistently near 100%, but Speech, Psych, Medical, and FSA were consistently lower; the graphs appeared to portray the tabular data accurately. The Monitoring Team reviewed the timeliness of assessments for a sample of completed ISPs, a sample of ISPs held during the monitoring visit as well as for as sample of upcoming ISPs. While assessment timeliness remained a concern, there was evidence that the Facility was achieving progress in this area. Findings included: • In the sample of seven ISPs completed prior to the monitoring visit (Individuals	

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		#42, #288, #317, #490, #567, #772, and #788), none (0%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. In several instances, assessments were not completed until well after the meeting was held. Overall for this sample, the rate of timeliness was 52%. It was generally not possible to ascertain assessments that might be missing altogether, as few of these had ISP Preparation meeting documentation that prescribed the required assessments; therefore this assessment is based on whether the available assessments were completed prior to ten days before the ISP annual meeting was held. • For a sample of seven individuals who had ISPs during the week of the monitoring visit (Individuals #19, #65, #231, #441, #626, #667, and #697), none of seven (0%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. The overall compliance rate was improving, however, at 78%. • The Monitoring Team also viewed the assessments available on the shared drive for Individual #520, who had an annual ISP meeting scheduled within the next ten working days. For 15 of the assessments that were required per the ISP Preparation meeting, 12 (80%) were available. This was consistent with the compliance rate for the ISP annual meetings held during the monitoring visit. DSSLC had produced a CAP for annual physician assessments to address assessments not being completed and saved in the folder timely. This CAP was due 3/22/13 for implementation 3/25/13. The data on timely assessments by discipline provided by the Facility showed a significant improvement in timeliness of medical assessments beginning in March 2013. For Individual #520, noted above, the physician annual assessment was provided more than 10 working days prior to the annual ISP planning meeting. Additional information for disciplines includes the following: • The 25 most recently completed Admission, Annual, and/or Quarterly Nursing Assessments were completed timely 81% of the time as require by Facility policy. This was consistent with the Facility's Self-Assessment, which showed nursing assessments were completed timely 82% of the time in April 2013. • Twenty of 22 individuals' OT/PT assessments in sample P.1 and P.2 (91%) were dated as having been completed at least 10 days prior to the annual ISP. Twenty-two of 22 assessments or updates in Sample P.1 and P.2 (100%) were current within 12 months for individuals who are provided PNM supports and services. • As reported in Provision R2, the Facility had a reasonable plan to	

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		screen/assess all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. DSSLC provides assessments for all new admissions in lieu of providing screenings. For nine of 10 individuals in Sample R.1 (90%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. For new admissions, the Monitoring Team reviewed completion of assessments within 30 days following admission for several disciplines. • As reported in Provision I2 for six newly admitted individuals sampled, the risk assessment was completed within the required timeframe. • As reported in Provision J2, eight individuals admitted between the last compliance visit and 5/28/13 took psychotropic medication at the time of admission, and they needed to have psychiatric evaluations. All eight Individuals (#212, #379, #463, #531, #604, #719, #783, and #791) received timely CPEs within 30 days. Three of the Individuals (#424, #694, and #770) did not take psychotropic medications and did not have psychiatric diagnoses. Those individuals were screened for psychopathology with Reiss screens. The results of the screen did not show a need for need for mental health services for any of the three individuals. • As reported in Provision P1, sixteen of 16 individuals (100%) admitted since the last compliance visit received a comprehensive OT/PT assessment within 30 days of admission. DSSLC does not do screening upon admission but, instead, conducts a comprehensive OT/PT assessment. The Monitoring Team considers the presence of assessments as meeting and surpassing compliance with this metric. • For Individual #694 who had been admitted since the last compliance visit, the Monitoring Team reviewed the Active Record and determined the dates of admission assessments. Of 10 clinical assessments required for all newly admitted individuals, eight (80%) were found in the Active Record. Eight of eight (100%) of the found assessments were completed prior to 30 days following admission. Overall, the Facility continued to attend to timeliness of routine and scheduled assessments, with indication that timeliness was improving. Given declines from September 2012 to January 2013, following which the Facility took action to increase timeliness again, it is evident the Facility will need to monitor timeliness carefully and take action as needed. <u>Comprehensiveness of Scheduled Assessments</u>	

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		Assessments for several disciplines had become more comprehensive, although improvement must still be made. • As reported in Provision J6, there remained a need for improvement in the quality of documentation in comprehensive psychiatric evaluations, although Facility psychiatrists had given increased attention to diagnostic justification. • As discussed in Section K, psychological evaluations did not consistently contain current intellectual or adaptive assessments, but significant improvement had occurred. Furthermore, comprehensiveness of completed evaluations had improved; the psychological evaluations included narrative summaries of how the results would facilitate understanding of the individual's strengths and needs. Functional assessments had also improved in comprehensiveness. • Provision L1 reports on the quality of medical summaries for several health conditions. The Monitoring Team found annual medical assessments had become much more comprehensive. Nevertheless, the comprehensiveness of these varied, with many excellent assessments but others that could have been more comprehensive. The report for that provision pointed out several situations in which assessments should more fully assess individuals for potential causes of a condition; this was reported for osteoporosis, for example. For myelopathy and degenerative spine disease, none of the annual medical summaries documented a physical assessment to accurately quantitate range of motion, muscle tone, and when possible, sensorium. • As reported in Provision M2, implementation of a revised nursing assessment monitoring tool was in process, and the Nursing Department was critically reviewing completed nursing assessments. Although most required components of the nursing assessments were present, there were still areas requiring improvement. Some involved accurate and current documentation of diagnoses; analysis of data on health status, diagnosis testing results, effectiveness of medications and treatments, and data related to nutrition and weight management. Summarized documentation did not consistently reflect whether individuals' health status was improving, maintaining, or regressing. • As reported in Provision P1, OT/PT assessments did not consistently include components that should be part of a comprehensive assessment. • As reported in Provision R2, most components expected of a comprehensive plan were found in 100% of communication assessments. Some components, such as a comparative analysis of health and functional status with the previous year, were found in none of the assessments. <u>Assessments and Evaluations in Response to Changes in Status</u> Improvement continued to occur in timeliness of assessments and evaluation in response to changes in status. For example:	

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		• As reported in Provision I2: o For six sampled individuals whose most recent risk assessment reported a change of status, for five (83%) the assessment process began within five days. o Based on a review of nursing risk assessment records of a sample of six individuals, all six (100%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was a significant improvement from the 50% compliance rate noted in the last report by the Monitoring Team. o Based on a review of PNMT records of a sample of five individuals for whom assessments had been completed to address the individuals' at risk conditions, all five (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. This was a significant improvement from the 16% compliance rate noted in the last report by the Monitoring Team. Furthermore, as reported in Provision O2, ten of 10 PNMT assessments in a sample were completed in no more than 30 days of the date initiated or no more than 45 days in extenuating circumstances. o Based on a review of risk records of six individuals (Individuals #379, #791, #463, #379, #791, and #463) with challenging behavior and/or polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, all six (100%) included a psychiatric assessment to assist the team in developing an appropriate plan. This was a significant improvement from the 0% compliance rate noted in the last report by the Monitoring Team. • As reported in Provision J7, the Facility put in place a process for evaluation for psychiatric services due to a change in behavioral status in July 2013. While this appeared to be an appropriate process, the Monitoring Team could not yet determine whether implementation would be consistent and comprehensive. • As reported in Provision O2, In ten of the ten individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT or discussion by the PNMT within five working days of the ISPA meeting and/or PNM incident. DSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Based on these discussions, if PNMT involvement was felt to be needed then the IDT was contacted so that a joint meeting would occur to discuss the findings of the assessment, concerns of the PNMT, and how the PNMT could support the IDT by providing a focused or full assessment or by merely	

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		discussing the issue and providing guidance to the individual's IDT. As a result, initiation and receipt of the referral occurred simultaneously and was within five working days. Use of Information from Assessments Examples were found both of use of information from assessments and of lack of use of the information. • As reported in Section O, PNMT assessments were important in planning services and supports, and information was used collaboratively with the IDT for assessed individuals. • As reported in Provision S1, information from the Functional Skills Assessment was not used consistently when developing goals and objectives. • As reported in Provision V4, during the ISP annual planning meeting for Individual #626, although there was extensive discussion by several IDT members on most issues, there was no reference to information from the assessments. Furthermore, lack of use of data during extensive risk review discussion hindered the process and possibly the accuracy of risk ratings.	
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.	Policy The revised DSSLC Policy CMGMT 03 Integration of Clinical Services requires clinicians to be responsible for accurate and complete diagnosis coding. As reported in Provision L1, all medical diagnoses in annual medical assessments were consistent with appropriate ICD-9 diagnoses. For the most part, medical diagnoses clinically fit corresponding assessments and evaluations. For osteoporosis, Provision L1 notes the need for improved assessment of underlying etiology or evidence that there was a review for secondary cause of the condition. This would be an area for improvement. As reported in Provision J2, the Monitoring Team reviewed the Active Problem Lists (APLs) of individuals in a sample. All had APLs with correct DSM terminology. Facility psychiatrists gave increased attention to diagnostic justification. DSM criteria for the proposed diagnoses were cited often and the diagnoses were discussed with those criteria in mind. However, the Monitoring Team found five of 16 (31%) of the sampled CPEs had good justification for all cited DSM diagnoses. Therefore, it was not yet clear that diagnoses clinically fit the evaluations. A positive finding was that for a sample of 15 Positive Behavior Support Plans (PBSPs), as reported in Provision J3, cited psychiatric diagnoses were consistent with information contained in psychiatric evaluations.	Noncompliance

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		The Facility needs to continue its general improvement in comprehensiveness of medical and psychiatric assessments, take care to identify conditions and individuals for whom improved assessment of underlying etiology or review for secondary cause may lead to improved treatment, and ensure CPEs include justification for diagnoses based on DSM criteria.	
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. The Facility had continued to make strides toward ensuring that medical treatments and interventions are implemented timely through the use of clinical indicators. Although that was not as clear for other clinical disciplines, timeliness had generally improved. In addition, most disciplines consistently provided clinical rationale for treatment decisions, but (along with some variability in timeliness) this was not yet consistent enough to achieve substantial compliance. <u>Timeliness of Implementation</u> Timeliness of implementation continued to improve in many areas but remained variable. • As reported in Provision K8, there were frequent delays in approval and implementation of PBSPs. Although the average time to approval by the peer review committee and Human Rights Committee was reasonable, some programs took extensive time (up to 104 days) to be implemented. Nevertheless, timeliness of behavior intervention had improved substantially. • As reported in Provision L1, there were examples in which treatment was timely based on assessments, and other examples in which timeliness could not be determined. o Fractures: there was excellent triage and follow-up on fractures by the medical provider. o Seizures: annual and quarterly medical assessments did not consistently document how well the seizure disorder was controlled, comment on frequency of seizures, or summarize efficacy of treatment. Therefore, it was unclear whether treatments and interventions were timely. • As reported in Provision O2, when an individual experienced a change in status, there was evidence of an IDT referral to the PNMT or discussion by the PNMT within five working days of the ISPA meeting and/or PNM incident. Assessments were generally completed within 30 days. There was documentation to confirm implementation within 14 days or sooner following the completion of an action plan. This was a good example of ensuring treatments and interventions were timely and clinically appropriate based on	Noncompliance

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		assessments. • As reported in Provision O3, for individuals for whom the PNMP was revised, there was supporting documentation that three of 24 individuals' revised PNMPs (12%) had been implemented. Per review of the Medication Administration Records (MARS), Dining Plans, and PNMPs in the "Me" books, there was a pervasive issue with consistency among documents as the vast majority were contained different revision dates and therefore contained different information. Therefore, it was difficult to evaluate whether treatments based on assessments were implemented timely. • As reported in Provision P2, plans for individuals receiving OT/PT supports and services were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. Direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • As reported in Provision R2, both for direct and indirect communication interventions, individual's direct communication intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. However, documentation for indirect communication services did not contain information regarding whether the individual showed progress. Review consisted of only stating that the service was provided and offered minimal information regarding effectiveness of supports in meeting desired outcomes. Therefore, it was difficult to determine whether revisions to interventions were made as needed. <u>Clinical Appropriateness</u> • As reported in Provision K9, PBSP records consistently documented the rationale for selection of the proposed intervention as well as description of potential function(s) of targeted behaviors. • As reported in Provision L1, annual medical assessments were more comprehensive than in the past, and follow up to many medical issues was also more comprehensive. Annual medical summaries included medical plans specific to conditions. Plans were generally clinically appropriate based on assessments. Findings for conditions reviewed by the Monitoring Team included: o Osteoporosis or osteopenia: ten of ten annual medical summaries indicated a plan, and appropriate treatment was provided as clinically indicated. o Recurrent pneumonia: Only six of ten (60%) individuals in a sample of those who experienced three or more incidences of pneumonia during the past five-year period had a diagnosis of recurrent pneumonia on the	

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		Active Problem List in the annual medical assessment. Five of ten action plans (50%) documented a clinically rational action plan. o Myelopathy/degenerative spine disease: documentation did not provide evidence of clinical follow-up with a spine specialist to provide ongoing monitoring for progression of the disease. • As reported in Provision P2, OT/PT assessments did not consistently identify the need for direct intervention with rationale. For individuals whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. • As reported in Provision R2, for individuals' records reviewed, the current SLP assessment identified the need for direct and indirect intervention with rationale. However, for individual-specific assistive communication systems, devices were not consistently present and available to the individual, and the Monitoring Team observed the device in use for only one of six individuals observed (16%).	
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.	<u>Policy</u> The revised DSSLC Policy CMGMT 03 Integration of Clinical Services had been revised substantively and includes a section on the use of clinical indicators. <u>Use of Clinical Indicators for Systemic Improvement</u> The Facility had continued to develop systemic clinical indicators of efficacy of treatments and interventions in health care and other clinical areas. The Facility provided a table of QA key/clinical indicators that included many indicators of the efficacy of treatment and interventions. A few of these were: • # of persons diagnosed with pneumonia or aspiration pneumonia • Instances of pseudomonas, respiratory infections, conjunctivitis, urinary tract infections, and several other acute conditions • Number of crisis intervention restraints • Decubiti by stage • Individuals with sugar above or below range These indicators were now being used routinely for quality assurance and improvement purposes and to identify issues requiring systemic action. The Monitoring Team was provided a copy of clinical indicators, dated May 2013, that included 73 clinical parameters, such as: ER visits, hospitalizations, pneumonia, aspiration pneumonia, loss of mobility, among others. The indicators are items used by the QA/QI department, to develop tracking and assessment measures. For example: • The QA/QI Council Data Review Meeting included review of numerous clinical indicators, including oral hygiene measures, decubitus ulcer number and	Noncompliance

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		severity, and number of infections. Review of the DSSLC QA/QI Council Meeting Minutes for January 2013 through June 2013, indicated that that tracked data for the clinical indicators, such as the incidence of pneumonia, UTIs, serious injuries, and loss of mobility, among many others, had been collected longitudinally, In addition, there was evidence to indicate that the data was analyzed, and that there were action plans, and follow-up to actions developed for outstanding issues. • As reported in Provision L3, the medical quality assurance program tracks a wide range of clinical parameter, including indicators such as incidences of pneumonia, urinary tract infections (UTIs), and loss of mobility. An example of a response to clinical indicators was an improvement program initiated in response to an increase in incidences of pneumonia. • As reported in Provision O1, the Physical and Nutritional Management Committee reviewed a set of clinical indicators monthly and developed action plans to address trends. These clinical indicators had been developed before the last compliance visit but had continued to evolve. An example of such an action plan was to slowly increase the rate of enteral nutrition in an effort to increase tolerance and work towards potential oral intake. Also, review of aspiration pneumonia frequency led to several actions, including actions at the Facility and training staff at a hospital on the use of suction toothbrushing. At the time of the last compliance visit, the PNMC had already taken improvement actions as a result of review of clinical indicators. One such action involved UTIs, for which there had been a reduction in incidences since the last compliance visit. The PNMC list of actions noted an increase in May 2013, with a response of opening additional stations around campus to obtain water during warm weather. This indicated ongoing review of the clinical indicators with action taken when appropriate. Refer to Provision H5 for additional information. <u>Use of Clinical Indicators for Decisions on Care for Individuals</u> The last report stated that clinical indicators of health status were used routinely in making decisions on health and behavioral services, but that it was not always clear that indicators were well-defined and clinically justified, and that modification of treatments and interventions reflected the use of indicators in identifying changes in status. The issue of use of clinical indicators to identify change in status will be addressed in Provision H6. As noted below, documentation was provided of clinical indicators for some conditions, but further development of clearly defined indicators continues to need to occur. • The Facility provided Integrated Health Care Plan Assistance documents for the following conditions: o Constipation	

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		o Osteoarthritis/Degenerative Joint Disease o Metabolic Syndrome o Urinary Tract Infection o Tuberous Sclerosis These provided definitions, diagnostic guidance, symptoms and manifestations, and other information. The formats for these were not consistent; clinical indicators were listed for osteoarthritis/degenerative spine disease and constipation, and monitoring components to be measured were listed for metabolic syndrome. These documents did not indicate any specific requirements or criteria for review but provided a good beginning to tracking and reviewing specific indicators to assist in decision-making on treatment. • The clinical indicators for osteoarthritis/degenerative spine disease and constipation were also included in the DSSLC Reference Material Index, a list of documents available for review by clinicians and Direct Support Professionals. • As reported in Provision J3, in the last report, the Monitoring Team noted that whereas the behavioral targets for intervention were defined in the PBSPs for most sampled individuals, few PBSPs contained defined behavioral targets for psychiatric treatments. The Facility has begun to address this issue by providing PBSP addenda with operational definitions for those behaviors. Such PBSP addenda had been prepared for six of 15 (40%) of the individuals in Sample J1, although not all of the PBSPs for those individuals had been updated to include the information contained in the PBSP addenda. One way to assess whether PBSPs contained the needed information about monitoring for medication treatment efficacy was to see if PBSP information on tracking matched the information in the psychiatrist's medication plans. In its own review of 25 records that was reported in the Self-Assessment, the Facility reported that PBSP and medication plans information matched in 50% of the records. • As reported in Provision P1, OT/PT assessments did not routinely include analysis that compared the individual's status with previous years or assessments. Although the Facility continued to make significant progress, particularly in using data from clinical indicators to identify systemic issues needing action, there needs to be more evidence that clinical indicators are routinely used in making decisions about treatment and interventions. To move toward compliance during the next six months, the Facility should consider: • Expanding gradually the number of conditions for which clinical guidance is provided (for example, seizures are a significant and common condition among the Facility population, but there is not yet a Health Care Assistance document for that). Further, these documents should include the clinical indicators that	

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		are to reviewed and reported. • Ensure assessments and other appropriate documents include comparisons of data on relevant clinical indicators to permit assessment of progress or regression in health status.	
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.	DSSLC Policy CMGMT 03 Integration of Clinical Services had been revised substantively and includes a section on monitoring health status of individuals. The policy assigns responsibility to the clinical discipline lead for identifying the level of oversight required. It also states that data can be "reviewed by the QAQI Council and/or O2." The Facility had continued to use or had established several systems to monitor the health status of individuals, including the following: • Clinical indicators, as reported in Provision H4 • The chronic care quarterly visit process • Regular review by the Physical and Nutritional Management Committee (PNMC). Clinical indicator data was being collected for analysis by the QA department, and was reported at the PNMC meetings. The role of this committee continued to include review of a wide range of health issues. • Maintenance of a database for trending blood sugar levels, as reported below. Examples of review of health status of individuals included: • As reported in Provision I2, review of 17 records (excluding the 10 reviewed specifically for Individuals with recurrent pneumonia) for individuals determined to be at risk there was documentation that: o Nine (53%) included the clinical indicators to be monitored and the frequency of monitoring. This was the case for Individuals #365, #279, #171, #665, #228, #211, #101, #66, and #499. This was a significant improvement from the 6% compliance rate noted in the last report by the Monitoring Team. • The Diabetic Nurse Educator maintained a database for trending blood sugar levels for all individuals' daily, monthly, quarterly and longitudinally. She analyzed and trended data for each individual, as well as campus-wide. This information was provided to the individuals' primary care provider and to individuals' endocrinologist at their appointments. These reports reflect individuals' current treatment regimen and were utilized to establish recommendations for changes in treatment. • Skin integrity data were reported along with supporting documentation monthly at PNMC meetings to keep the IDTs informed of the status of individuals' skin integrity issues, as well as the incidences of skin integrity and pressure ulcers campus-wide. The first skin integrity data was presented to the PNMC on	Noncompliance

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		6/14/13, as verified in the minutes. In addition, as a clinical key indicator pressure data were provided monthly to the QA/QI Council meetings for review and disposition. • Based on review of individuals' records who were referred to the PNMT, ten of 10 (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. • One purpose of PNMC was to review facility data to resolve systemic issues and concerns. 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 were: • Hospitalizations • ER visits • Deaths • Skin Integrity • Enteral Nutrition • Aspiration Pneumonia • Pneumonia • Falls • Diabetes Management Report • Individuals followed by PNMT and the PNMT's level of involvement • UTIs • Pseudomonas The PNMC meeting attended by the Monitoring Team included review of systems issues in an effort to have a positive impact on care at a facility level. The PNMC provided a detailed review of clinical indicators with a special emphasis on the root cause of Pneumonia. There was active conversation by all members of the committee. Although the clinical indicators were available for review of health status along with other information, such information was not consistently used in development of healthcare plans, and monitoring was not always done consistently. • As reported in Section O, there was limited evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status as well as limited to no monthly review by the QDDP. • As reported in Provision O7, there was not evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews only stated if changes were made to the PNMP and provided no information regarding status of the individual.	

#	Provision	Assessment of Status	Compliance
		• As reported in Provision M2, reviews of health status from previous quarter/annual, including any surgeries were not consistently documented in Section XI of the annual and quarterly nursing assessments. Also, although there was significant improvement in summarizing raw clinical data, the summarized documentation did not consistently reflect individuals' health status (that is, whether they were improving/progressing, maintaining, or regressing in health status). The Facility had other processes to monitor health status of individuals. • As reported in Provision J2, the Psychiatric Medication Review (PMR) was held monthly for each individual who received psychotropic medications. This brought together several IDT members, who provided relevant information. • The Integrated Morning Report provided an opportunity each day for communication of changes in health status, as reported in Provision G1. The Facility is approaching substantial compliance with this provision. An area for improvement remains ensuring monitoring is done regularly and documents progress or regression based on data and other information.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The revised DSSLC Policy CMGMT 03 Integration of Clinical Services had been revised substantively and includes a section on modifying treatments and interventions in response to clinical indicators. DSSLC had made gains in identifying and tracking clinical indicators and maintained a system for monitoring a limited number of chronic medical conditions. The Facility had developed Integrated Health Care Plan Assistance documents and provided those for five conditions (for more information, see Provision H4); three of these (Constipation, Osteoarthritis/degenerative spine disease, and metabolic disorder) included clinical indicators or issues to monitor, but they did not provide guidelines for when to modify treatments and interventions in response to the indicators being monitored. Further development of such documents, both in terms of the breadth of conditions covered and in the clarity of guidance regarding tracking clinical indicators and modifying treatments and interventions, could be useful in ensuring treatments and interventions are modified in response to clinical indicators. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Although there are numerous examples throughout this report of timely modification of treatments and interventions, there remained problems with monitoring of clinical indicators and with accuracy of the data used for decision-making. • As reported in Provision O7, zero of the 12 individuals' records in Samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM. • As reported for Provision M2, for items assessed that related to individuals' high/medium risks and/or active medical problems for which nursing was responsible, the summary analyses of data were not consistently documented, and/or when clinical data were summarized, the documentation did not consistently reflect the relation of individuals' health status to the data. • As reported in Provision L1, for Individual #170, there were a total of 12 seizures reported on seizure record forms; however, the cumulative seizure record had not been updated since February, and did not reflect the 12 seizures that had been reported (although note that the cumulative seizure record for Individual #595 had been updated). Furthermore, of the five individuals reviewed, the annual assessment commented on frequency of seizures for only one. • As reported in Provision K4, 79% of PBSP either showed progress or that the program was modified within three months. This was a slight reduction from the last compliance visit.	
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.	As reported in Provision G1, DSSLC Policy CMGMT 03 Integration of Clinical Services had been revised. This purpose of this policy was to "provide integrated clinical services… to ensure that individuals receive the clinical services they need. Treatments and interventions shall be modified in response to clinical indicators." The revised policy addresses assessment, development and use of clinical indicators for monitoring health status of individuals and for "solving problems associated with the delivery of clinical services." A draft DADS state policy was available that addressed Provisions G and H together. The policy was not yet completed or disseminated. Information about this draft policy can be found in the report of the last compliance visit to DSSLC.	Noncompliance

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 3. Section I Presentation Book (undated) 4. DADS Policy 006.1 At Risk Individuals 12/7/12 5. DSSLC Policy CMGMT -14 At Risk Individuals 1/15/13 6. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 6/17/13) 7. Record reviews: Sample O.2 Individuals #42, #66, #92, #101, #211, #218, #228, #492, #565, and #739 8. Individual Support Plans (ISPs) for all sampled individuals 9. Completed Physical Nutritional Management Plans (PNMPs) for all sampled individuals 10. Tools used to monitor implementation of PNM procedures and plans 11. Record reviews for Individuals #326, #42, #129, #305, #551, #20, #739, #690, #466, #664, #228, #211, #101, #66, #499, #365, #279, #553, #566, #171, #665, #379, #791, #463, #379, #791, and #463 (sample selected for data analysis) 12. Integrated Risk Rating Form and Risk Action Plan for Individuals #333, #386, #704, #171, #553, #566, #273, #365, #34, #279, #665, and #83 13. List of Top 10 individuals causing injury to peers 14. List of Top 10 injured individuals. 15. List of individuals supported with bedrails 16. List of individuals injured from bedrails **People Interviewed:** 1. Nancy Condon, Facility Director 2. Donna Groves, OTR, Director of Habilitation Services 3. Brief discussion with living area staff while making observations **Meetings Attended/Observations:** 1. Physical and Nutritional Management Team 7/23/13 2. Physical and Nutritional Management Committee 7/25/13 3. ISP meetings for Individuals #19, #441, and #626 4. Observation at multiple living areas
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. 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. For Section I, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff:

	o The monitoring/audit tools the Facility used to conduct its self-assessment included the standard Section I monitoring tool, the ISP monitoring tool, QA/QI reports, and various data reports. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. This sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources and/or key indicators/outcome measures. For example, reviewing databases that showed trends in key clinical areas such as multiple diagnoses of aspiration pneumonia, skin breakdown, hospitalizations, and infectious diseases. ▪ Generally presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. The Facility rated itself as being in compliance with the Provision I.1 of Section I. This was not consistent with the Monitoring Team's findings. The Monitoring Team did not find the Facility in compliance with any of the three provisions in Section I. While the Facility had a system for regular risk screening and assessment it was not always being conducted in such a manner as to produce reliable results. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as complete or in process. Of the 56 action steps reported in the Action Plan 52 (93%) were reported as completed. ▪ The Facility data identified areas of need/improvement primarily related to additional staff training and continued implementation of the at-risk policy. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility

	also used supplementary tools that IDTs could use in the risk assessment planning process. The Facility had initiated a Facility specific policy (CM 14) addressing its At Risk system. 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. The Monitoring Team observed three ISP meetings held during the week of the review. Participation by relevant staff and use of clinical data in reviewing risk was improved from that noted at the last review. The IDTs did not always consider the interrelationship between various risk conditions. The risk assessment process in place at the Facility did not always accurately assess risk and consider discipline specific clinical information, and the interrelationship with other clinical data, when reviewing risk. Risk ratings did not always adequately rate the individuals on all risk categories based on supporting clinical data. Interdisciplinary clinical coordination had improved from that noted at the last review. While much improved from that noted at the last review the 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' health status based on medical history, treatment regimens, and other supporting clinical data that was noted. Many of the compliance scores reported in Provision I.2 and I.3 had improved significantly from that reported in the last report by the Monitoring Team but still remain at an unacceptable level.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	As was noted in its last two reports 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. The Facility had also initiated a Facility specific policy (CMGMT 14) addressing its At Risk system. As reported in Provision I.3 substantial progress had been made using this process to assess risk and develop appropriate risk action plans. Compliance scores in all areas experienced significant improvement since the last review by the Monitoring Team. The Facility continued to have a very active Physical and Nutritional Management	Noncompliance

#	Provision	Assessment of Status	Compliance
		Committee (PNMC). This group met at least monthly (usually several times a month) 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 Provision of the SA. As reported in Section O of this report the work of this committee has led to significant improvement in the risk assessment process related to physical/nutritional management issues. While this part of the risk assessment process had experienced significant improvement it should be noted the risk assessment process includes many elements beyond the purview of the PNMC/PNMTs. In its last report the Monitoring Team noted processes that were expected to lead to improved assessment and addressing of risk included: • The Hospital Liaison Nurses routinely attended Integrated Morning Report meetings and reported on hospitalized individuals. They maintained ongoing communication with the RN Case Managers, Unit Directors, Qualified Developmental Disability Professionals (QDDPs), Skin Integrity 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. • The Diabetic Nurse Educator was working collaboratively with the IDTs and Pharmacist to identify early, individuals who may be at risk for metabolic syndrome. These activities remained in place and have proved beneficial in the risk assessment process. The Monitoring Team observed four ISP meetings held during the week of the review. Staff present at the ISPs was the actual staff who worked with the individual, and it appeared all staff needed at the ISP meeting was in attendance. The individual was present at three ISP meetings although in one case the Individual left early because of a medical issue (the physician at the ISP assessed the Individual and sent him to the ER). For the one meeting where the Individual was not present it was at the request of his guardian 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	

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		open discussion among IDT members. In most cases the IDT used clinical data in determining risk levels and developing rationale for these determinations. The ISP meeting for Individual #626 did not include presentation of behavioral data. Refer to Provision V.4 for additional information. One of the IDTs engaged in substantive discussion on how risk impacted potential alternative placement in a more integrated setting. This was the case for Individual #441. In two meetings the ISP facilitator kept the team discussion focused. This was not the case for the ISP meeting for Individual #19. The IDTs did not always consider the interrelationship between various risk conditions. For example, in observing the ISP meeting for Individual #441 the Monitoring Team noted that although the risk guidelines were referred to in determining risks the IDT needed to enhance skills in critical thinking regarding the interrelationship between the various risk conditions within a particular group of risk conditions, as well as the interrelationship between the various risk rating groups in order to accurately determine risk ratings. While the risk guidelines serve some useful purpose in assisting with risk level determination, the sole reliance on the guideline prohibits the IDT from independent/critical thinking. The risk assessment process in place at the Facility did not always accurately assess risk and develop and/or implement mitigation plans commensurate with the identified risk. Refer to the discussion in Provision I.2 regarding individuals with recurrent pneumonia. Additionally, as reported in Provision O.2, PNMT assessments and reviews lacked evidence that all potential areas impacted by a change in PNM status were reviewed and discussed as part of a PNMT meeting. Examples of issues identified and reported in Provision O.2 include: Based on review of individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: • Four of 10 (40%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component evident if there was not a formal PNMT evaluation. • Four of seven (57%) who received enteral nutrition had identified residual thresholds, for return to the PNMT. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting and evaluation. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting.	

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		• Four of 10 (40%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting. • Four of 10 (40%) contained evidence of review/analysis of lab work. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting. • Four of 10 (40%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component when there was not a formal PNMT referral and evaluation. • Four of 10 (40%) contained oral hygiene status. This information was contained within the Habilitation Assessment but there was no evidence of review of this component if there was not a formal PNMT referral and evaluation. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In four of the 10 individuals' plans reviewed (40%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In four of the 10 individuals' plans reviewed (40%), the plans included the specific clinical indicators of health status to be monitored. • In zero of the 10 individuals' plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Although indicators had been listed for some, objectives were not established. • In two of 10 individuals' plans reviewed (20%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. The issue noted was that once the action plan was handed down to the IDT, the tracking of steps to ensure completion was not evident. For example: The PNMT recommended that Individual #492 receive a mobility assessment as well as testing for H Pylori. There was no evidence of IDT follow up to ensure completion. In its last report the Monitoring Team noted that 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	

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		surveillance program. The Facility had developed and implemented a comprehensive policy to address this; however, during the course of this review the Monitoring Team continued to find instances of bedrail application and safety issues. For example, when making observations and talking with staff the following issues were apparent: staff were not always trained on proper use of bedrails including getting the rails up and down; staff were not always putting new pads on correctly (e.g. upside down, not secured); in one instance the Monitoring Team noted a broken railing and the staff had no idea it was broken - three staff were needed to put the railing up and down and staff did not realize that the railing was broken and dangerous; and, some bedrails in use were "makeshift", departing from manufacturing specifications. A few improvements were noted by the Monitoring Team. For example, the use of homemade wooden bedrails had ceased and some new rail guards (POSEY) that fit under a mattress were observed. While the Facility had a system for regular risk screening and assessment it was not always being conducted in a comprehensive manner producing reliable results. This Provision was not in substantial compliance.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The Facility in its self-assessment of this provision reported an overall compliance rate of 83%, noting a 100% compliance rate for the last three months of its use of the Section I monitoring tool. In many areas of risk assessment the Monitoring Team also found a high level of compliance. The Monitoring Team selected 27 records to review to assess compliance with this provision. These were for Individuals #326, #42, #129, #305, #551, #20, #739, #690, #466, #664, #228, #211, #101, #66, #499, #365, #279, #553, #566, #171, #665, #379, #791, #463, #379, #791, and #463. For 10 of these Individuals (#326, #42, #129, #305, #551, #20, #739, #690, #466, and #664) the Monitoring Team reviewed at risk issues related specifically to recurrent pneumonia experienced by these Individuals. Six out of ten annual medical assessments (60%) listed a diagnosis of recurrent pneumonia on the associated active problem list. • The Annual Medical Assessments for Individuals #664, #466, #739, and #326 did not indicate recurrent pneumonia or history of recurrent pneumonia on the action plan component of the annual medical assessment. Five out of ten action plans (50%), as listed on the annual medical assessment, documented a clinically rational action plan for recurrent pneumonia. For example: • The action plan for Individuals #466 and #690 documented a comprehensive action plan that discussed, in addition to medical management, specific positioning issues, and in the case of Individual #690, what to observe for.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The action plan for Individual #129 merely stated "H/O Asthma and recurrent pneumonia in the past. Since the admission since 11/11, the patient has been stable with pulmonary status". There was no discussion about risk issues, and positioning issues. It should be noted that the individual was hospitalized for a significant case of pneumonia in May 2013. There was indication that a specialist was consulted, specifically to help identify factors, and strategies to help minimize recurrent pneumonia, in two of ten examples (20%) • The Monitoring Team noted the consult report dated 6/5/13, that documented an excellent overview of the individual's history of pneumonia, and potential for developing additional pneumonia in the future. There was no comment regarding possible procedures to help reduce aspiration pneumonia, such as fundoplication, and tracheal diversions; and there was no comment on issues related to positioning. The Monitoring Team reviewed associated integrated risk rating forms, and all indicated some risks for either pulmonary issues, and/or aspiration risks; however, in general, the risk ratings did not provide an adequate reflection of the serious risks associated with aspiration pneumonia. For example: • The most recent IRRF for Individual #664 indicated a medium risk for respiratory compromise, and that there had been no pneumonia since June 2012. The risk factor for aspiration was also rated medium and stated "had no aspiration pneumonia in the past year, and the team agreed that the current plan was working well to prevent aspiration pneumonia". This individual had five episodes of aspiration pneumonia in the past five years, has a diagnosis of pharyngeal dysphasia, and history of rumination of food and more than five episodes of aspiration pneumonia in the past. • Individual #466 had experienced 12 episodes of pneumonia during the past five years, with the most recent episode occurring in March 2013. Although the risk rating for respiratory compromise was high, the IDT did not comment on the specific risk factors for recurrent aspiration pneumonia. When discussing the current status for respiratory compromise, the IDT responded by stating: "supports appear to be somewhat effective as evidence by several diagnosis of respiratory compromise documented this year", and for proposed recommendations, the IDT indicated "no new recommendations made before the ISP". With a history of 12 incidences of pneumonia in the past five years, three of them occurring during the previous year, and one as recent as two months before development of the IRRF, the Monitoring Team has serious concerns over the Facility's ability to identify and develop meaningful action plans for risks of serious clinical conditions.	

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		The Monitoring Team recognized the extraordinary efforts made by the Facility to help reduce the incidences of pneumonia, and realizes that in some cases, the incidence may not be able to be eliminated; however, issues such as potential medical treatments (such as tracheal diversion and fundoplication), effective monitoring of supports (such as assistance with meals, transfers, and position), and early recognition of signs of pneumonia, must all be well incorporated into the risk assessment, and the risk action plan, for each individual with pneumonia associated risks. Refer to Section L of this report for additional information. For the other 17 records reviewed, the most recent risk assessment for these 17 individuals reported a change in status in six cases. These were for Individuals #665, #228, #211, #101, #66, and #499. In five (83%) the assessment process started within five days. The exception was for Individual #665. Six of the 17 Individuals were new admissions, and initial risk assessments were done within the timeframe prescribed in policy. The remaining five Individuals had recent risk assessments which did not indicate a change in status. Based on a review of nursing risk assessment records of a sample of six of these individuals (Individuals #365, #279, #553, #566, #171, and #665), all six (100%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was a significant improvement from the 50% compliance rate noted in the last report by the Monitoring Team. Refer to Section M of this report for additional information. Based on a review of PNMT records of a sample of five of these individuals (Individuals #228, #211, #101, #66, and #499) for whom assessments had been completed to address the individuals' at risk conditions, all five (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. This was a significant improvement from the 16% compliance rate noted in the last report by the Monitoring Team. Refer to Section O of this report for additional information. Based on a review of risk records of six individuals (Individuals #379, #791, #463, #379, #791, and #463) with challenging behavior and/or polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, all six (100%) included a psychiatric assessment to assist the team in developing an appropriate plan. This was a significant improvement from the 0% compliance rate	

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		noted in the last report by the Monitoring Team. Refer to Section J of this report for additional information. While the Facility has made much progress in moving towards compliance with Provision I.2 this Provision remains out of compliance.	
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.	Refer to Provision I.2 for discussion relevant to Provision I.3 with respect to 10 Individuals with recurrent pneumonia. For the other 17 Individuals discussed in Provision I.2, based on a review of 17 records (excluding the 10 reviewed specifically for Individuals with recurrent pneumonia) for individuals determined to be at risk there was documentation that the Facility: • Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in eight (47%)) cases. This was the case for Individuals #228, #211, #101, #66, #499, #553, #171, and #665. This was a significant improvement from the 6% compliance rate noted in the last report by the Monitoring Team. • Implemented a plan that met the needs identified by the IDT assessment in 12 (71%) cases. This was the case for Individuals #379 (polypharmacy risk and challenging behavior risk), #365, #279, #553, #171, #665, #228, #211, #101, #66, and #499. This was a significant improvement from the 6% compliance rate noted in the last report by the Monitoring Team. • Included preventative interventions in the plan to minimize the condition of risk in 13 (76%) cases. This was the case for Individuals #379 (both polypharmacy risk and challenging behavior risk), #365, #279, #553, #566, #171, #665, #228, #211, #101, #66, and #499. This was a significant improvement from the 11% compliance rate noted in the last report by the Monitoring Team. • When the risk to the individual warranted (five cases), the Facility took immediate action in each. This was the case for Individuals #228, #211, #101, #66, and #499. • Integrated the plans into the ISPs in seven (41%) cases. This was the case for Individuals #379 (both polypharmacy risk and challenging behavior risk), #228, #211, #101, #66, and #499. Five additional Risk Action plans were attached (without reference in the ISP) to the ISP. This was the case for Individuals # 365, #279, #553, #171, and #665. This was a significant improvement from the 6% compliance rate noted in the last report by the Monitoring Team. • In 11 (65%), the risk plans showed adequate integration among all of the appropriate disciplines, as dictated by the individual's needs. This was the case for Individuals #379 (both polypharmacy risk and challenging behavior risk), #365, #279, #171, #665, #228, #211, #101, #66, and #499. This was a	Noncompliance

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		significant improvement from the 11% compliance rate noted in the last report by the Monitoring Team. • In eight (47%), 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 Individuals # 365, #553, #171, #665, #211, #101, #66, and #499. This was a significant improvement from the 6% compliance rate noted in the last report by the Monitoring Team. • Nine (53%) included the clinical indicators to be monitored and the frequency of monitoring. This was the case for Individuals #365, #279, #171, #665, #228, #211, #101, #66, and #499. This was a significant improvement from the 6% compliance rate noted in the last report by the Monitoring Team. While significant improvement in compliance ratings was noted this Provision remains out of compliance.	

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment (7/8/13) 2. DSSLC Action Plan (AP) (6/21/13) 3. Facility Presentation Book for Section J for July 2013 visit (undated) 4. DADS Policy and Procedures 007.3 Psychiatry Services (05/01/2013) 5. DSSLC Policy CMGMT 24 Strategies to Reduce Medical/Dental Restraint (04/19/13 draft) 6. DSSLC Procedure and Procedure Dental Services IV Sedation DS-24 7. Document describing Facility understanding of routine and non-routine medical procedures 8. DSSLC Order Form for Medical and Dental Restraint (updated 05/04/13) 9. DSSLC Process for Evaluation for Psychiatric Services Due to Change in Behavioral Status (03/08/2013) 10. DSSLC HRC review form for psychotropic medications (03/22/13) 11. Nursing Department attendance sheet for nurse case managers who received annual refresher training in January 2013 12. Current HRC review form for new medications (06/01/13) 13. DSSLC Pharmacy Policy #47 Pharmacy Metabolic Syndrome Risk Monitoring Policy (revised 09/15/12) 14. A list of all individuals who received psychiatric care, including the current psychiatric diagnoses, name of the treating psychiatrist, psychotropic medications given to the individual, and date of the Appendix B psychiatric evaluation 15. 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) 16. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Psychoactive Medication Oversight Committee (PMOC), since the last compliance visit 17. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 18. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2010 until the present 19. A separate list of individuals for whom each of the following was prescribed: a. Anticonvulsant medications used only for psychiatric indications b. Anticonvulsant medications used only for neurological indications c. Anticonvulsant medications used for both neurological and psychiatric indications d. Lithium e. Tricyclic antidepressants f. Trazodone g. Beta blockers being used as a psychotropic medication h. Clozaril/Clozapine

	i. Mellaril j. Reglan k. Anticholinergic medications l. Benzodiazepines 20. A list of individuals who had medical support plans and dental support plans to reduce the need for pre-treatment sedation 21. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation [Total Intravenous Anesthesia (TIVA) or oral] 22. A list of all individuals screened for tardive dyskinesia with Dyskinesia Identification System Condensed User manual (DISCUS) evaluations 23. DISCUS forms done over the past year that were rated "5" or higher 24. A list of all individuals diagnosed with tardive dyskinesia 25. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effects evaluations 26. A list of individuals diagnosed with tardive dyskinesia and the Active Problem Lists (APL) for each of those individuals 27. Reiss screens (both data and scoring sheets) done since the last review 28. A list of all individuals whose scores matched or exceeded Reiss Screen cut-off values per instrument guidelines 29. Description from DSSLC of the procedures considered routine care and procedures considered to be non-routine (undated) 30. Materials presented to the treating psychiatrists for Psychiatric Medication Review (PMR) clinics on 07/24/13 and 11/24/13 for Individuals #204 and #704 31. Sample J1: Case reviews for individuals considered by the Facility to be stable on their current psychotropic medication, individuals with complex pharmacological regimens, and individuals with Individual Support Plans (ISPs) during the visit. These were Individuals #19, #116, #117, #152, #230, #285, #399, #482, #622, #628, #629, #667, #696, #764, and #765, 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 (PMR) d. Most recent Positive Behavior Support Plan (PBSP) and Structural and Functional Behavioral Assessment e. Most recent Individual Support Plan (ISP) 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 (QDRR) for the past six months k. Most recent Health Risk Assessment Rating tool and team meeting sheet l. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors -copies of the plan to reduce risk (ISP addenda) m. Medical and/or dental plans to increase cooperation/participation and reduce the need

	for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation 32. Sample J2: Episodes of medical and dental restraint for Individuals #222(3/7/13), #299(3/6/13), #368(2/12/13), #371(3/7/13), #482(2/8/13), #526(1/8/13), #572(4/25/13), #706(1/10/13), #761(2/27/13), #759(4/4/13), and #774(2/21/13). 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. 33. Sample J3: 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 #82 (Trazodone), #89 (Prozac), #110 (Remeron), #123 (Lamictal), #212 (Tegretol and Risperdal), #238, (Zydis)#248 (Zoloft), #259 (doxepin), #356 (Tegretol), #367 (Depakote), #398 (Aricept), #463 (Klonopin, Ativan, Ambien, Seroquel), #379 (Seroquel, Klonopin, Zyprexa), #783 (Geodon, Zoloft, Lithium,), #637 (Pamelor), #531 (Invega), #273 (Zyprexa and Klonopin), #791 (lithium and Risperdal) 34. Sample J4: Documents related to psychiatric and neurological care for five individuals who took anticonvulsant medications for both neurological and psychiatric indications. Individuals reviewed were #4, #119, #299, #335, #533, and #776. Materials were neuropsychiatry conference minutes from 07/24/13 and the most recent PMR clinic visit notes to help the Monitoring Team understand the underlying neurological and psychiatric matters that were discussed. 35. Sample J5: 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 #379, #463, #531, and #791 Materials reviewed included: a. The most recent Risk Assessment b. The initial ISP c. The initial psychiatry assessment d. Documentation of assessments and other steps taken to develop an AP to reduce risk e. The AP to address the risks (either ISPA or new ISP) 36. Sample J6 Moses and DISCUS screen done since the last visit. These were for Individuals #19, #68, #116, #117, #152, #240, #285, #320, #398, #399, #482, #581, #622, #628, #629, #632, #667, #696, #721, #735, #764, #772, and #781. The individuals were those in Sample J1 (case reviews) and individuals who were reviewed for PBSP addenda and other cases reviewed during the visit. **People Interviewed:** 1. Arifa Salam, MD, Lead Psychiatrist 2. Robert Hardin, MD, Staff Psychiatrist 5. Randy Spence, BCBA, Director of Behavioral Services

	6. Delia Schilder, RN, Chief Nurse Executive (CNE) 7. Sibylle Graviett,, RN, Nurse Case Manager Supervisor **Meeting Attended/Observations:** 1. PMR clinic with Dr. Salam, 07/23/13 2. PMR clinic with Dr. Hardin, 07/23/12 3. Psychiatric Medication Review Committee 07/23/13 4. Meetings on 07/22/13 with Ms. Lori Powell and Dr. Arifa Salam about psychiatry quality assurance (QA) 5. ISP Annual Planning Meeting for Individual #19 on 07/23/13 6. Neuropsychiatry conference on 07/24/13
	Facility Self-Assessment: Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) self-rating. For Section J in conducting its self-assessment, the Facility ▪ Documented the use of monitoring/auditing tools for Provision J4. For that provision the Facility reported compliance ratings for provision C5.5 of the Facility Restraint audit tool, as it related to medical restraint. That monitoring tool included adequate indicators to allow the Facility to determine compliance with the part of Provision J4 that related to monitoring for safety during the restraint procedure per nursing protocol or as ordered by a physician. The monitoring tool for that part of the provision included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The tool monitored for the presence of documentation that the safety checks were performed at the required frequencies during the restraint and in that manner did include an adequate methodology. The Self-Assessment for medical monitoring during restraint identified the sample size (84 of 394 medical restraints, 21% of all medical restraints documented over a six month period from 11/01/2013 to 04/30/2013). That sample size was adequate to consider it to be a representative sample. Audit Information was not provided about inter-rater reliability between the various staff members responsible for the completion of the tool. ▪ Did use other relevant data sources. For example, the Facility used o Tracking databases and spreadsheets for ▪ All individuals followed by psychiatry that included dates of completion of initial and annual psychiatric evaluations, assignment to staff psychiatrist for ongoing care and clinical diagnoses ▪ Dates of completion of required MOSES and DISCUS evaluations ▪ Completion of PBSP, medication plan, and informed consent, ▪ Use of chemical restraints ▪ Frequency and type of polypharmacy ▪ Pharmacy and psychiatry tracking for dual purpose medications ▪ Facility wide tracking of individuals diagnosed with tardive dyskinesia The spreadsheets and databases were key to the self-assessment for Provisions J3,

	J11, J12, and J15 o Chart reviews for 25 of 248 (10%) of individuals followed by psychiatry, for the presence of required elements for Provisions J2, J3, J6, J8, J9, J10, and J13. ▪ Presented data in a useful way. In particular, the self-assessment organized the presentation and the supporting data in a manner that was responsive to the items addressed by the Monitoring Team in the recent visit. Also, the Self-Assessment provided information on areas of strength and weakness and the status of progress. For example, in Provision J4 the Facility stated "there is not currently a mechanism in place to determine if all individuals who receive medical restraints have an ISP AP to minimize or eliminate restraints, such as a desensitization plan. A system is currently being developed to address this issue at the Center by first delineating which medical restraints were for routine procedures (versus non-routine procedures) and then a tracking system for ISP documents to identify of strategies and supports to reduce or eliminate restraints for non-routine medical procedures." Overall, the Self-Assessment addressed the right issues and organized the materials well. The above notwithstanding, the tools and metrics used by the Facility often reported on the presence of required items but did not measure the quality of those items. Important comments about quality were therefore not supported by appropriate metrics. In the Self-Assessment for Provision J6 the Facility came to a similar conclusion and acknowledged that "there is a need for improvement in the quality of documentation related to justification for psychiatric diagnosis, clarity of identified symptoms, and discussion about pharmacological interventions." Overall, the Facility did not present findings based on specific measurable indicators that clearly identified what was being measured or the criteria for measurement. In some cases the report also did not distinguish data collected by the QA department vs. the program/discipline. Due to the lack of information about specific indicators or tools, it was not possible to determine whether data were derived solely from the Psychiatry Department or if QA data were used as well. All of these limited the utility of the self-assessment. The Facility rated itself as being in compliance with the following Provisions of Section J: J1, J2, J5, J7, J10, J11, J12 and J15. The Monitoring Team's agreed with those findings except for Provision J10, where timely HRC review of IDT risk/benefits was not provided. For two of the Provisions (J7 and J12) the determination of substantial compliance was new. That reflected the overall progress made by the Facility and its focus on the specific issues for those provisions which had been identified to be in need of improvement. The Facility also provided as part of its self-assessment an AP that reported actions being taken to achieve compliance. As with the Self-Assessment, the AP items focused on the items identified by the Monitoring Team as in need of improvement. That was helpful. Here too, how achievement of those goals would be assessed was not spelled out. For example the first action step was "Provide more detailed review of psychiatric symptoms in course of illness." Perusal of the Facility AP for other sections of the SA showed that in many cases the "Evidence" column of the AP cited specific tools or assessment that would indicate whether the needed work had been done. In this and other action steps the evidence cited to support progress was only a citation of the underlying source document, in this case the annual psychiatry

	summary and psychiatric evaluation document. Deployment of citation of specific and measurable indicators as evidence would assist the Facility in its work.
	Summary of Monitor's Assessment: During the current review period two provisions came into status of substantial compliance. For Provision J7 the Facility administered the Reiss Screen across the campus for all individuals who needed the screen and assured the psychiatric evaluations were provided for the individuals who screen positive for possible mental health disorders. The Facility also established a process for use of the Reiss Screen in response to behavioral changes in status. The Monitoring Team found that the Facility had met the requirements for substantial compliance with Provision J7. For Provision J12 the Facility completed its deployment of MOSES and DISCUS screens in response to individual's changing needs, and the Facility continued to provide administration of the screens at the intervals required for routine monitoring. The Monitoring Team found that a good system was in place for administration and review of side effect screens and the Facility has met the requirement for substantial compliance with Provision J12. Provisions J1, J2, J5, J11 and J15 remained in substantial compliance. Progress was made in other areas: • For Provisions J3 and J13, the Facility has initiated a process to establish tracking for efficacy of psychiatric medications, by beginning deployment of PBSP addenda that identify how treatment efficacy will be assessed. • For Provision J4, the Facility has developed guidelines for defining which medical procedures are considered routine. • For Provision J8 and J9 the Facility continued to improve presentation of information in the ISP. • For Provision J14, the Facility has addressed the matter of delays in timely review of proposed medication by the HRC. Areas where continued improvements are needed include: • Completion of the project to improve PBSPs by identifying how treatment efficacy will be assessed (Provisions J3 and J13). • Completion of efforts to provide individuals who need pre-treatment sedation with programs to reduce the need for sedation (Provision J4). • Inclusion of key psychiatric treatment information in ISPs (Provision J8 and J9).

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services	<u>Qualifications of the psychiatrists</u> At the time of the last visit five psychiatrists were employed by the Facility, and all	Substantial Compliance

	only by persons who are qualified professionals.	continued their employment at the Facility. Drs. Ranganath Habbu, Arifa Salam and Satyajit Satpathy continued to work as full time staff psychiatrists, and Drs. Robert Hardin and Howard Lagrone worked as contract psychiatrists. Dr. Salam was the Lead Psychiatrist for the Facility. All psychiatrists had current licensure in the State of Texas. Drs. Hardin, 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. <u>Experience of the psychiatrists</u> To provide quality care at the Facility, psychiatrists needed experience working with individuals who had both intellectual disabilities and mental health needs. The experience of Drs. Hardin, Lagrone, Salam, and Satpathy were reviewed during previous visits. The Monitoring Team had planned to interview Dr. Lagrone during the current visit and that interview was scheduled. Due to circumstances beyond his control, Dr. Lagrone was unable to be present at the Facility during the visit. As a result, that interview will take place during the next visit. Dr. Lagrone's curriculum vita was reviewed. As Lead Psychiatrist, Dr. Salam was familiar with details of Dr. Lagrone's work prior to coming to the Facility and helped the Monitoring Team understand his prior experience working with individuals who had both intellectual disabilities and mental health needs. Dr. Lagrone has worked with dually diagnosed individuals in a number of settings. He worked as a locum tenens psychiatrist at the Mexia SSLC for four months in 2010. He also had experience working with dually diagnosed individuals in 1993 and 1994 when he worked as Departmental Staff Psychiatrist at the Texas Tech Regional Health Science Center in Amarillo. Dr Lagrone also worked with individuals with dual diagnoses when he was Staff Physician at the Panhandle Mental Health Authority in Amarillo, Texas, between 1994 and 1997. Dr. Lagrone continued to see individuals with dual diagnosis in his private practice in Amarillo, between 1998 and 2002. <u>Observations during the visit</u> During the tour the Monitoring Team observed the work of Facility staff psychiatrists in their PMR clinics (Drs. Hardin and Salam) during an infirmary morning meeting, in the Psychotropic Medication Oversight Committee (PMOC) monthly meeting (Drs. Habbu, Salam, and Satpathy), during a neurology-psychiatry conference (Dr. Satpathy) and during an ISP meeting (Dr. Habbu). These activities are described in Provisions J2, J3, J8, J9, J10, and J15 of this report. The Monitoring Team found that the psychiatrists participated meaningfully in these activities and showed appropriate expertise relevant to the care of individuals with dual diagnoses. <u>Monitoring Team's Compliance Rating</u>	

		The Monitoring Team found that the psychiatric staff at DSSLC consisted of qualified professionals who participated meaningfully in the interdisciplinary process. The Monitoring Team found that the Facility has remained in substantial compliance with the requirements of this provision.	
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>Facility Use of Psychotropic Medications</u> As of 6/1/13, 248 of 489 (51%) of individuals who lived at the Facility received psychotropic medications. All needed to have clinically justified evaluations and diagnoses. <u>Facility Processes for Evaluation and Diagnoses</u> The Monitoring Team again observed the psychiatrists' day-to-day work in the various settings and meetings where individuals were seen and their care was discussed. Psychiatrists at the Facility conducted scheduled monthly meetings with individuals in the psychiatry clinic. These were known at the Facility as PMR meetings. The general format was that the nurse case manager presented information on physical health and MOSES and DISCUS side effect screens. 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. Psychiatrists also participated in various interdisciplinary meetings and conferences where discussion of diagnosis could be included. These meetings included the Psychoactive Medication Review Committee (PMRC), a medical morning (integrated morning report) meeting, neuropsychiatry conferences between psychiatrists and a consulting neurologist, various IDT meetings and ISP meetings. During the visit the Monitoring Team attended two PMRs, both on 07/23/13. In each PMR there were substantive clinical discussions about the clinical diagnosis of the individual under review. • Individual #204 was diagnosed with autism and tardive dyskinesia. There was a discussion of symptoms of increased motor activity characterized by the psychiatrist as "*running, skipping, running into objects/people causing falls to self and others with injuries, very difficult to redirect, grabbing others aggressively, disorganized behaviors (attempting to eat paint, drinking out of a toilet when he knows how to access fluids from the kitchen), sleeping less than usual.*" In her summary, the psychiatrist also added: "*Diagnosis of Bipolar II disorder, manic without psychosis was added today.* *(The Individual) previously was diagnosed with Bipolar I but no clear documentation of mood episode in the past and no history of major depressive disorder. Current episode has been going on for 2 months and worsening symptoms include sleep less than usual, hyperactivity, agitation , running fast into object and people fall/injury due to increased PM activity, aggression toward*	Substantial Compliance

		others, disorganized behaviors, etc. No indication of psychosis." During the PMR there were also observations about the individual's mild movements that were discussed and which were the basis for confirmation of the diagnosis tardive dyskinesia. The above was evidence of the psychiatrist's attentiveness to a changing pattern of symptoms and the understanding of those symptoms in the DSM diagnostic schema. This was done in a manner that integrated knowledge of the relevant diagnostic criteria, attentiveness to current clinical symptoms, and knowledge of the individual's past psychiatric history. This was an example of good diagnostic practice. • Individual #704 was diagnosed with Dementia, Alzheimer's type. During the PMR there was a review of the current symptoms that were the basis for the diagnosis of dementia, and review of the neurology consult from 3/13/13 that reviewed the individual's status for cognition and dementia. The Integrated Morning Report meeting was a daily meeting attended by on-call clinicians, and representatives of various disciplines. The Monitoring Team attended the Integrated Morning Report Meeting on 07/23/13. The meeting was well attended and focused on acute medical care. Data relevant to psychiatry was discussed during the presentation of medical difficulties evaluated by the on-call clinicians. The Monitoring Team attended the neuropsychiatry conference that took place on 07/24/13 that is described in Provision J15. As part of their routine review the psychiatrist and neurologist shared the relevant diagnosis and examined how the medicines in question impacted on those diagnoses. The Monitoring Team observed the annual ISP conference for Individual #19 who was diagnosed with Intermittent Explosive Disorder. Psychiatric information was presented and reviewed at the meeting during discussions of the IRFF and during the overall discussion of the Individual's behavioral health status. The meeting contained an example of integrated care between medical and non medical professionals, DSPs, and included meaningful participation the individual's sister who was his LAR. The topic under discussion was the possibility of the individual's possible transition to another residential home. There was an active discussion on how to provide the Individual with behavioral supports, if changes in residence were unavoidable; that discussion took his psychiatric symptoms into account. <u>Key Clinical Indicators for Quality of Care</u> 1. <u>Comprehensive Psychiatric Evaluations (CPEs) in place:</u> The Facility reported that CPEs were in place for all of the individuals who were followed by psychiatry. Annual psychiatric updates were done prior to the annual ISP	

		meetings. Annual psychiatric updates done before the annual ISP were provided for each of the 15 individuals in Sample J1. 2. Use of Diagnostic and Statistical Manual (DSM) diagnoses throughout the clinical record: The Monitoring Team reviewed the APLs of individuals in Sample J1. All had APLs with correct DSM terminology. 3. The use of NOS diagnoses: The Monitoring Team reviewed the department database for diagnoses for individuals followed by psychiatry. There were nine individuals with NOS diagnoses that were awaiting resolution. 4. Internal referrals to psychiatry: During the review period there were three referrals to psychiatry. The Monitoring Team confirmed that all had CPEs as part of their evaluation. 5. Timeliness of psychiatric evaluations for new admissions: As of 5/28/13 there had been 11 admissions to the Facility since the last visit of the Monitoring Team. Eight of the individuals took psychotropic medication at the time of admission, and they needed to have psychiatric evaluations. All eight Individuals (#212, #379, #463, #531, #604, #719, #783, and #791) received timely CPEs within 30 days. Three of the Individuals (#424, #694, and #770) did not take psychotropic medications and did not have psychiatric diagnoses. Those individuals were screened for psychopathology with Reiss screens. The results of the screen did not show a need for need for mental health services for any of the three individuals (see Provision J7). 6. Facility Tracking of Diagnoses: During the visit, the Monitoring Team reviewed the records of the 15 individuals in Sample J1. 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. 7. Changes of Diagnosis: During the review period 19 of 248 (8%) of individuals had changes in their psychiatric diagnoses. The Monitoring Team confirmed that the changes in diagnosis were entered into the Psychiatry Department database. The Monitoring Team did not confirm during this visit that APLs for those individuals were updated in the records, but previous checks of that did not show difficulties. Monitoring Team's Compliance Rating The Monitoring Team continued to find a good clinical process in place to provide and update CPEs for individuals who needed them, a good system was in place to track diagnoses, and records accurately recorded current diagnoses in the DSM format. The Monitoring Team found the Facility remained in full compliance with the requirements of this provision.	
J3	Commencing within six months of the Effective Date hereof and with	PBSP documentation Psychotropic medications were given to 248 of 489 (51%) of the individuals who lived at	Noncompliance

	full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	the Facility. The key requirement of the provision was that such medications should not be used as a substitute for a treatment program. To assess the status of this provision, the Monitoring Team reviewed the treatment program of the 15 individuals in Sample J1, all of whom took psychotropic medications. Since the core behavioral health care document was the PBSP, the Monitoring Team first 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, although the Facility Self-Assessment acknowledged that some needed to be brought up to date. Review of key elements from the 15 PBSPs that had information in the current format showed the following: • <u>Psychiatric Diagnosis:</u> PBSPs for 15 of 15 (100%) of the individuals contained the individual's diagnosis or diagnoses. In all cases it was in the DSM format and the cited diagnoses were consistent with the information contained in the psychiatric evaluations. • <u>Identification of the problem and need for behavior supports:</u> This PBSP section typically outlined the general problems the individual experienced and the interventions used to provide needed supports. This section was present for 15 of 15 (100%) of the individuals and in all cases psychotropic medications were identified in the PBSC section as one of those supports. • <u>Psychiatric case formulations:</u> These were present in 13 of 15 (87%) of the PBSPs. • <u>Differentiation of learned problem behaviors and psychiatric symptoms/behavioral characteristics:</u> These were present in 11 of 15 (73%) of the PBSPs. The extent of the discussion in the PBSPs varied from a few lines to several paragraphs. The quality of the information and the depth of the clinical presentation varied from case to case. In all cases, however, it was clear that the writers made a genuine effort to describe how IDT members understood which behaviors were the result of psychopathology and which reflect learned behaviors. A typical example was the PBSP for individual #696 that stated: *"In order to determine the best course of treatment for the response class of "depression," function assessment procedures included this response class. Results of the functional assessment procedures indicated that "depression" occurs most frequently under the function of automatic reinforcement, and because there are no concerns at this time about the social inappropriateness of "depression," this response class will be treated as a psychiatric symptom using psychiatric medications.* On the other hand, for the same individual,	

		"Physical aggression and self injurious behaviors have been determined to be learned behaviors maintained by environmental consequences. These behaviors will continue to be treated with behavioral intervention rather than psychiatric supports" In this example, the IDT provided a clear understanding of how biological and psychological processes operated in parallel. Of course, sometimes, the differentiation was necessarily more nuanced. For example, for Individual #764: *Verbal disruptive behavior is not a symptom of depression. It is thought the verbally disruptive behavior is functional in nature and not tied with (the individual's) symptoms of depression. It should be noted that when (the individual) is suffering more with symptoms of depression her motivation to participate in activities is greatly affected, and she may be more likely to use verbally disruptive behaviors to escape demands."* The language clarifies how depression and functional behaviors are separate, but linked. In some case differentiation of function was challenging. For example, for individuals #667: *"The psychiatrist and psychologist agree in recommending bites others, repeats phrases, and irritability are observable and measurable signs or symptoms of Intermittent Explosive Disorder. Analysis of functional assessment information suggests that these behaviors are a combined function of both the psychiatric disorder and learned behavior. The treatment should be a combined treatment involving simultaneous psychiatric and behavior analytic interventions."* Cases where differentiation of function are not possible are inevitable, but when they occur more scrutiny must be paid to the psychiatric diagnosis and treatment to assure the medication treatments are focused and appropriate. Overall, it appeared to the Monitoring Team that genuine efforts were being made across the campus to clarify how psychiatric and psychological factors effected individuals, and the results informed the combined case formulation and joint treatment plans. • <u>Information describing the medication and how it is used:</u> 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 14 of 15 (93%) of the PBSPs in Sample J1. Overall, the Monitoring Team found that the methodology of inclusion of the MPs into the PBSPs was effective, since it provided the needed information as written by the psychiatrists who prescribed the medications. • Monitoring for treatment efficacy: In the last report, the Monitoring Team noted that whereas the behavioral targets for intervention were defined in the PBSPs for 11 of 21 (52%) of the individuals, few PBSPs contained defined behavioral targets for psychiatric treatments. As described in more details under Provision J13, the Facility has begun to address this issue by providing PBSP addenda with operational definitions for those behaviors. Such PBSP addenda had been prepared for six of 15 (40%) of the individuals in Sample J1, although not all of the PBSPs for those individuals had been updated to include the information contained in the PBSP addenda. One way to assess whether PBSPs contained the needed information about monitoring for medication treatment efficacy was to see if PBSP information on tracking matched the information in the psychiatrist's medication plans. In its own review of 25 records that was reported in the Self-Assessment, the Facility reported that PBSP and medication plans information matched in 50% of the records. For Sample J1, the same information matched in only two of 15 (13%) of the records. Appropriate use of medication: During the visit the Monitoring Team attended two PMRs. The following observations were made about medication use and the assessment of medication effects: • For Individual #204: The graphic presentation of medication dose and psychiatric symptoms shared the same time frames and the data showed that as psychiatric symptoms of "irritability" and "grabbing aggressively" increased, the dose of Zyprexa was increased in response. Medication decisions appear to have been informed by agreed-upon target symptoms. • For Individual #704 graphing showed improvement with the introduction of a phase line on the graph showing when Doxepin had been discontinued as a treatment. The graphs demonstrated variability of the target symptoms over time (wandering, crying) in a manner that appeared to capture the symptom profile over time and to therefore inform the psychiatric decision-making. The Monitoring Team also attended the annual ISP for Individual #19. The ISP presentation by the psychiatrist included a review of the medication given to that	

		individual. The medications were appropriate for the individual, and were well integrated into the overall treatment plan. <u>Medications used for staff convenience</u> 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. <u>Medications used for punishment</u> To determine whether this was done, the Monitoring Team considered observations made during the tour, and reviewed the records of the 15 individuals in Sample J1. There was no evidence that medications were used for punishment. <u>Chemical Restraint</u> There was no use of chemical restraint at the Facility during the review period. <u>Monitoring Team's Compliance Rating</u> Presentation of the treatment program and overall use of medications continued to improve. Improvement is need in the area of psychiatric symptoms tracking and integration of information from the PBSP addenda into the full PBSP. For now, the provision remains in noncompliance with the requirements of the SA.	
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>Use of Pre-treatment Sedation at the Facility</u> The provision aims to minimize or eliminate the need for pre-treatment sedation for routine medical and dental care for individuals. During previous visits the Facility had clarified what it considered to be routine vs. non-routine procedures in the dental clinic. During the current review period the Facility developed and reported to the Monitoring Team working definitions of what constituted routine medical procedures. Use of pre-treatment sedation for such procedures was considered to be a use of medical restraint. The Facility reported as follows: Routine Medical Procedures These procedures are typically done without sedation for most people. They would include: • Non –invasive diagnostic procedures such as stress tests and EKGs • Phlebotomy • Many imaging studies such as x-rays, Deacon, ultrasound • IVs and hemlocks • Injections and immunizations Non-Routine procedures – these procedures are frequently or always done with sedation or sedations are offered as needed/requested. The procedures would include:	Noncompliance

		• Invasive-diagnostic procedures, colonoscopy • Most painful procedures, venapuncture and arterial blood gases • Procedures requiring no movement - MRI, mammograms if person has involuntary movement due to medical or psychiatric condition • Mediports, etc • Surgeries • Inserting PICC lines When a procedure was considered routine and sedation was required, protocols for medical sedation were followed. The Facility developed an *Order Form for Medical Dental Restraint* (updated 05/04/12). The form included the following sections: • Clinical Justification/reason for use of restraint. The form required the physician to outline whether the procedure was considered routine, and the reasons sedation was required for routine procedures. • Type of restraint ordered (including oral and iv sedation) • Monitoring Schedule: The physician indicated that the monitoring should follow nursing protocols for *Pretreatment and Post-sedation care* or *Post - Anesthesia Care.* The former was used for oral sedation protocols and the latter for TIVA <u>Amount of use of pre-treatment sedation</u> The Facility provided the Monitoring Team with a list of all uses of dental and medical pretreatment sedation for the period beginning November 2012 until the end of April (six months). During that period the Facility reported that pretreatment sedation was used for 82 dental procedures and 71 medical procedures. The Facility also reported to the Monitoring Team that dental pre-treatment sedation (oral or TIVA) was used for 18.4% of 954 dental procedures. That would amount to about 178 procedures, but it was not clear over what period of time that was. The Monitoring Team will seek clarification at the next visit. <u>Monitoring for Safety during Medical Restraint</u> The Facility continued to use the 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 Monitoring Team reviewed a sample of 11 individuals who received pretreatment sedation procedures on specified dates (Sample J2). The sample was selected haphazardly from a sample of fifteen instances of medical and dental pretreatments that was provided by the Facility. The review showed that in 11 of 11 (100%) of the	

		individuals the physician ordered monitoring per Facility protocol (for example, vital sign monitoring over 24 hour period, with initial monitoring prior to medication administration and every 30 minutes thereafter). The protocol was followed in 11 of 11 (100%) cases. However, a different sample comprised of individuals who had dental pre-treatment sedation showed no evidence to support that nursing staff or DSPs monitored the individuals during the 24 hours following the procedures (see Section Q). Plan to reduce the need for pretreatment sedation The Facility clarified that there was not currently a tracking mechanism in place to determine if all individuals who receive medical restraints have an ISP AP to minimize or eliminate restraints including strategies or treatments to reduce restraints, such as a desensitization plan. In the Self-Assessment the Facility also clarified that there was a plan for a tracking system for ISP documents to identify presence of strategies and supports to reduce or eliminate restraint for nonroutine medical procedures. The Monitoring Team reviewed the 11 individuals in Sample J2. These were individuals who received pretreatment sedation procedures. Ten of 11 individuals (91%) had appropriate authorization (i.e. Human Rights Committee approval and adequate consent) for the use of the pre-treatment sedation. Six of 11 (55%) included appropriately developed treatment or strategies to minimize or eliminate the need for pretreatment sedation. For five of these six (83%), the treatments or strategies to minimize or eliminate the need for the pre-treatment sedation were implemented as scheduled. Monitoring Team's compliance rating The Monitoring Team noted improvement in the monitoring for safety during pre-treatment sedation. Difficulties with development, implementation and tracking of supports to minimize the use of restraint persist. For those reasons the provision remains in noncompliance with the requirements of the SA.	
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.	Psychiatric Staffing As of 6/1/13, 248 out of 489 (51%) of the individuals who lived at the Facility received psychiatric support. At the time of the last visit there were five psychiatrists who were employed by the Facility, and all continued their employment at the Facility throughout the review period. Drs. Ranganath Habbu, Arifa Salam and Satyajit Satpathy continued to work as full time staff psychiatrists. Drs. Robert Hardin and Howard Lagrone continued to work as contract psychiatrists. At the time of the visit Dr. Hardin provided clinical services to the Facility for about 14-16 hours per week, and Dr. Lagrone came to the Facility for 4-6 hours on one day of the week. Thus, the overall level of psychiatric staffing was 3.5 FTE, and the average psychiatrist caseload for active care was about 71 individuals per FTE psychiatrist. Distribution of Effort	Substantial Compliance

		At the time of the visit, Drs. Habbu, Hardin, Salam, and Satpathy provided direct psychiatric support to individuals. Drs. Habbu, Salam, and Satpathy had clinical caseloads of 73, 69, and 73, respectively. Dr. Hardin had a caseload of 26 individuals. The lower caseload for Dr. Hardin reflected his part time status. In her role as Lead Psychiatrist Dr. Salam 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. Dr. Lagrone's work focused exclusively on internal quality assurance. In that work he reviewed clinical records. That work had started during the review period and results were not yet available. 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 PMRC. Facility psychiatrists received administrative support from two psychiatrist assistants, Ms. Brenda Morris and Ms. Devon Wince. The psychiatric assistants provided the psychiatrists with administrative support such as scheduling and support with the preparation of materials and documents for PMRs and other scheduled activities. The psychiatric assistants also prepared summaries of meetings and reports, and they maintained departmental records. Psychiatric assistants also participated in neurology/psychiatry conferences, tracked the information reviewed, and brought that information to the relevant PMR meetings. The assistants helped the psychiatrists via tracking of labs and other clinical materials. <u>Determination of Required FTEs</u> In the previous report the Monitoring Team reported that it concurred with the Facility that there were 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 and the Facility remains in substantial compliance for this provision of the Settlement Agreement.	
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.	<u>Appendix B Evaluations completed</u> As of 06/01/13, the Facility reported that CPEs were in place for all 248 individuals followed by psychiatry. <u>Review of Completed Evaluations</u> The Monitoring Team reviewed the most recent CPEs for the 15 individuals in Sample J1. CPEs reviewed were six to ten single spaced pages and they followed the recommended format. In the previous report the Monitoring Team had commented on the need to complete	Noncompliance

		needed evaluations and to focus efforts on improvements in diagnostic justifications, case formulations and resolution of NOS diagnoses. Those items were the focus of the current review. Facility psychiatrists gave increased attention to diagnostic justification. DSM criteria for the proposed diagnoses were cited often and the diagnoses were discussed with those criteria in mind. Five of 16 (31%) of the CPEs had good justification for all cited DSM diagnoses. Examples of diagnostic justifications that the Monitoring Team concluded met the requirements were Individuals #230, #622, and #764. Good case formulations were present in three of fifteen (20%) of the evaluations. Most of the CPEs had good case summaries but not formulations. The differences between the two were cited in a previous report along with an article reference on the matter. Two of the better formulations were those for Individuals #230 and #696 and the Monitoring Team found these to be adequate. In those cases, the psychiatrist synthesized information in a way that emphasized critical elements of the case and provided an integrated understanding of the individual. <u>Monitoring Team's Compliance Rating</u> There remained a need for improvement in the quality of documentation in CPEs. The Facility is aware of the need, as discussed in the Self –Assessment. The Monitoring Team agreed with the Facility's Self-Assessment.	
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	<u>Reiss Screens for Individuals who lived at the Facility</u> As of 06/01/13 there were 489 individuals residing at the Facility. Two hundred forty eight of the 489 individuals received ongoing support from the psychiatry clinic, and all of those individuals had psychiatric evaluations in place. The remaining 241 individuals on campus did not receive psychiatric services, and 100% of those individuals received a Reiss screen between 12/01/12 and 03/31/13. The Reiss screens were administered and scored in accordance with the instructions in the Reiss manual. Scoring was done using software provided by the developer of the tool. The Facility reported that 11individuals screened positive. All 11 (100%) were referred for psychiatric evaluation. The Monitoring Team confirmed that all 11 received the required psychiatric evaluations. <u>Negative Screens</u> The Monitoring Team requested the list of individuals who were reported to have had a negative screen. From that list the Monitoring Team selected a sample of 50 of 241 (21%) individuals: Every 5th individual from the list was selected until the required number was reached. For each individual, the Monitoring Team reviewed the actual Reiss Screen and the scoring sheet for the administration. The Monitoring Team confirmed that all individuals had indeed screened negative.	Substantial Compliance

	comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Positive Screens</u> The Monitoring Team requested the names of the 11 individuals who screened positive, and the psychiatric evaluations that were done as a result. These were Individuals #172, #189, #357, #423, #560, #564, #594, #609, #674, #687, and #713. The Monitoring Team reviewed each of the psychiatric evaluations that were done. Individual #560 was recommended for ongoing support but ongoing psychiatric services were not recommended for the others. The Monitoring Team found that reasonable judgment was made by Facility psychiatrists in these decisions about who needed treatment. <u>Reiss Screens for Recent Admissions</u> Since the last visit there were eleven admissions. These were Individuals #212, #379, #424, #463, #531, #604, #694, #719, #770, #783, and #791. Eight of the individuals took psychotropic medications, were referred to psychiatry, and received psychiatric evaluations. Those individuals did not need a Reiss Screen. Three individuals did not take psychiatric medications. Those were Individuals #694, #424, and #770. The Monitoring Team reviewed the Reiss Screens and the Reiss Screen scoring sheets for those three individuals and confirmed that the Reiss Screen was negative. <u>Reiss Screens for Change of Status Evaluations</u> In July 2013 the Facility put in place a process for evaluation for psychiatric services due to a change in behavioral status. The purpose of the procedure was to identify what needed by Behavioral Services staff and the IDT when there was a behavioral change in status for an individual who did not receive ongoing psychiatric care. The steps involved were completion of a Reiss screen and a psychological assessment or update of the current assessment, completion of a dementia screening tool if that is appropriate, an IDT meeting and then a consultation request for psychiatry assessment if that is deemed appropriate. The evaluation would be scheduled as soon as possible but no later than 30 days from the receipt of the consultation request. The referral would be accompanied by the documentation mentioned above. <u>Monitoring Team's Compliance Rating</u> The Monitoring Team confirmed that all individuals seen by psychiatry had a psychiatric assessment in place. The Monitoring Team also confirmed that that Reiss Screens were in place for all individuals on campus (including new admissions) and that the administrations of the screen were done correctly. The Monitoring Team confirmed that all individuals who had screened positive were referred for comprehensive psychiatric evaluation and received those evaluations. An adequate procedure was in place for the use of the Reiss Screen during evaluations for a behavioral change of status. The Monitoring Team found that the Facility has met the requirements of the provision and is found to be substantial compliance with the requirements of this provision.	

		The Monitoring Team notes that an adequate change of status protocol was in place but it had not yet been used. During the next visit the Monitoring Team will inquire whether there have been any change of behavior status evaluations, and appropriate use of the protocol will be required for a continued finding of substantial compliance.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Provision J8, through its focus on combined assessment and case formulation, focused on integrated care. As outlined in previous reports, the Facility had 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 were required by this provision. Some of these were the PMR clinics, medical reports, and the PMRC and ISP meetings. The Monitoring Team observed each of these clinical settings 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. The Facility's plans to bring information together to provide the required assessments were outlined in the AP section of the self-assessment. The four elements of the AP brought together contributions from the clinical meetings and discipline-specific assessments, into the PBSP and the ISP. That was appropriate, since the PBSP presented the combined work of the behavioral healthcare team, and the ISP presented the overall work of the entire IDT. The Facility reported progress in several areas. During the current visit The Monitoring Team assessed this provision by review of evidence the Facility provided for progress, by observing the settings and meeting where integrated case was provided, and by reviewing PBSPs and ISPs. 1. <u>PBSP to be completed in a timely manner following the new format with integration of information from psychology and psychiatry:</u> Facility efforts in this area continued. The Facility provided a sample of a PBSP with integrated psychiatric information for Individual #231. That plan included a psychiatric case formulation and a section of differentiation between learned problem behaviors and psychiatric symptoms that provided clear descriptions of why the diagnoses of Tourette's Disorder and Generalized Anxiety Disorder were justified. The formulation also clarify that some challenging behaviors were best understood as learned behaviors, serving purposes such as access to preferred activities and to escape demands. The PBSP also contained a very useful table that provided operational definitions of key psychiatric symptoms that were targets of medication interventions. These were anxiety, irritability, and vocal motor tics. These operational definitions provided guidance about what was measured by psychologists during PMR meetings, and	Noncompliance

		provide a basis for informed decisions about medication efficacy. During the visit the Monitoring Team learned that a campus-wide effort is underway to introduce the above information into all PBSPs. This was being done in a two step process. In the first step a PBSP addendum was being written that contained psychiatric information like the table that defined the psychiatric symptom/target behaviors. These had been prepared for 63 of 248 (25%) of the individuals followed by psychiatry. The second step was to incorporate the information in these addenda into the overall PBSP, for example at the time of the annual review of the PBSP. This had not yet taken place for all the individuals who had PBSP addenda. PBSP addenda had been completed for six of 15 (40%) of the PBSPs of individuals in Sample J1, but the information in the addenda had not yet been brought into an updated PBSP for all those individuals (see discussion under Provision J3). 2. <u>PBSP to include discussion about psychopathology, medication plans, 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 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. 3. <u>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:</u> This is the information required by Provision J9, and the Monitoring Team's observations are reported under that provision. 4. <u>Integration of information from psychiatric assessment and treatment plan in a meaningful manner in the ISP document:</u> Facility efforts at improvement focused on improvements in the ISP, IRRF and integrated risk and healthcare plans. To assess the current status of development of ISPs the Monitoring Team reviewed recently developed ISPs for three new admissions, Individuals #379, #463 and #791. Psychiatric information was included in summaries of psychiatric care and in the IRRF. The quality of the presentation varied. The ISP for Individual #379 had an excellent presentation of the psychiatric issues present on admission, the IRRF contained specific information relevant to ongoing care, and there was a good AP for high risk psychiatric issues (polypharmacy and challenging behavior) that was integrated into the Integrated Health Care Plan (IHCP). For Individual #791 the ISP contained a good summary of the initial psychiatric presentation, but the information was not integrated into the APs. For Individual #463, information from the IRFF was not included in the ISP or resulting IHCP. <u>Monitoring Team's Compliance Rating</u> The Monitoring Team noted progress, albeit limited, in the area of integrated care. The	

		progress was evident in some improvements in PBSP integration, per the above and per information discussed under Provision J3. Progress was also evident in improvements in ISP presentation of psychiatric information, per the above. The Monitoring Team agreed with the Facility Self-Assessment that there is need for further improvement in PBSPs, in psychiatric symptom tracking, and inclusion on meaningful psychiatric information in ISP documents. These are needed to integrate pharmacological treatments with behavioral and other interventions though combined assessment and case formulation.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	<u>Psychiatry Participation in PBSP and other IDT activities</u> To meet the requirements of this provision, psychiatrists need to be involved in the development of the PBSP as specified in the wording of the settlement agreement. 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 Direct Support Personnel (DSPs). At times, legally authorized representatives (LAR) s 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. Treatment plans were developed after discussion and input from all IDT members to ensure that the interventions in place are the least intrusive and most positive to treat the behavioral or psychiatric condition. The IDT also determined during these meetings if individuals would best be served through behavioral interventions, pharmacological interventions, other interventions, or a combination of these interventions. Psychiatrists also participated in psychoactive medication review committee meetings, in Integrated Morning Report, and in regularly scheduled interdisciplinary conferences such as the neuropsychiatry conference. Psychiatrists were regular participants in annual ISP meetings for individuals under their care. Descriptions of these processes under Provisions J2, J3, J11, and J15 document that there were active interdisciplinary activities during the above-cited meetings. The place in the record where the results of those discussions were documented was the PBSP and, more broadly, the ISP. Prior to the visit the Facility conducted a review of 25 of 248 (10%) of the records. The Facility reported that in that sample it found that 73% of the records audited had updated PBSPs, 91% of Integrated Risk Rating Forms contained relevant psychiatric information. 83% of the records contained relevant APs for the behavioral health section of the Integrated Risk Rating Form with medium and high risk ratings. The Monitoring Team reviewed the three required elements of the provision by examination of PBSPs of individuals in Sample J1.	Noncompliance

		<u>That the least intrusive and most positive interventions to treat the psychiatric condition were used</u> PBSPs typically contained a section called "Attempts at Less Restrictive Practices." These reviewed current and past treatment and provided information to assure that the IDT had considered the requirements cited above. A typical example was Individual #667: *"Many behavioral techniques have been used with (the Individual), with varying degrees of support. Supports for hand biting, throwing objects, and aggression were used for at least twenty years (some of these supports included more restrictive devices and procedures such as mechanical and physical restraint, time out, and response-cost procedures). The current program emphasizes early support to prevent escalation of behaviors."* The IDT discussed the risks associated with the treatments, protections and supports contained in this PBSP. *"The possible risk associated with the behavioral supports in this plan are ostracism and ridicule (the Individual's) peers for receiving behavioral treatment, a worsening of the challenge behavior or increased resistance to treatment if these procedures are ineffective , a risk of harm to staff who are required to intervene when (the Individual) becomes aggressive. These risks were compared to the risks associated with the targeting challenging behaviors. The IDT determined that the risks of the treatment and supports were less than the risk associated with the challenging behavior (rage) and that the supports and treatment are a viable and potentially valuable approach to alleviation or those behaviors and symptoms and possible subsequent removal of the attendant risk."* The above statement included sufficiently specific information to assure the Monitoring Team that the IDT was knowledgeable about the individual and had chosen less restrictive and most positive techniques. The details of the program were provided elsewhere in the PBSP. Similar sections were located in the PBSP's of 15 of 15 (100%) of individuals. All were specific to the individual and his/her circumstances. <u>That medication treatment would also be accompanied by non-pharmacological support</u> All the PBSPs reviewed were for individuals who received pharmacological support. For these individuals, information about non–pharmacological supports was provided in many places in the PBSP. The place where details about both pharmacological and non-pharmacological supports were contained was the section on differentiation of learned behaviors and psychiatric symptoms. That section was provided for 11 of 15 (73%) of the PBSPs.	

		Whether the individual was best served though behavioral, pharmacological or other interventions, in combination or alone All PBSPs in Sample J1 contained information on pharmacological information and all PBSPs contained information about behavioral treatment. Many contained information about other interventions. However, the Monitoring Team found that a mere listing of treatments provided did not meet the requirements of the SA. For that, active IDT consideration of which treatments best served the individual was needed. An example of a PBSP that addressed the requirement well was for Individual #765. For that individual there was a detailed discussion of the symptoms followed by a statement that *"Analysis of function assessment information suggests that these psychiatric symptoms, although they are comprised of operantly learned behaviors, primarily occur due to establishing operations that are hypothetically manipulated as a result of (the Individual's) psychiatric condition. The primary treatment should be psychiatric with adjunctive behavioral hygiene support provided through the PPSP (emphasis added).* Overall, the Monitoring Team Found that 10 of 15 (67%) of the plans addressed the requirement adequately. Examples of plans that did not were PBSPs for Individuals #399 and #285. Monitoring Team's Compliance Rating As outlined under Provision J2 and J3, and other, the quality of the IDT discussions in PMR and elsewhere is good. Progress is being made to update PBSPs and to include needed psychiatric information in ISPs. For now the provision remains in non-compliance with the requirements of the provision.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable	Policy and Procedure DADS policy and procedure "Psychiatry Services" dated 05/01 2013 noted that the State Center responsibilities included that " before the non-emergency administration of a new psychotropic medication or a significant change in the dosage of a psychotropic medication, the IDT, including the psychiatrist primary care physician, nurse, individual and legally authorized individuals (LAR) must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medication. This determination may occur in person or through telephonic communication, including during the psychiatric clinic, and the determination must be documented in person." Processes in place for Risk Benefit Assessment	Noncompliance

	alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	The place where discussions about medication (including risk/benefit analyses) took place was the PMR. PMRs often took place on a monthly basis, and in no circumstances did they occur less than quarterly. As presented in more detail under Provision J2 Interdisciplinary Team (IDT) participation in the clinics included the psychiatrist, Qualified Developmental Disability Professional (QDDP), nurse case manager, psychologist and direct care professionals (DCP). Primary care physicians (PCPs) attended when possible; at other times the psychiatrist called the PCP as needed to discuss relevant issues. Reviews of risk and benefit also took place via the IRRF process, in the general medical settings such as morning report and elsewhere in the IDT process. For new medications, risk benefit documentation was in the medication plan (MP) that was subsequently reviewed by HRC as part of the informed consent process (see discussion for Provision J14). For medications prescribed on an ongoing basis, risk and benefit analyses were part of the format for quarterly reviews in the PMR. The relevant section called for IDT discussion about the use of polypharmacy, assessment of risk vs. benefits, treatment rationale, and alternative treatment strategies. Medication plans were re-written annually as part of the annual review process, prior to the ISP. <u>Quality of the Risk Benefit Assessment</u> During the visit, the Monitoring Team observed discussion about risk and benefit during two PMRs, a PMOC meeting, an ISP conference, and a neuropsychiatry conference. The quarterly PMR review for Individual #204 included a detailed discussion of current and past side effects of Zyprexa, alternative treatments (medication and non-medication) were discussed, the QDRR which included review of labs and possible risk was reviewed as were the results of MOSES and DISCUS side effect screens. The quarterly PMR review of Individual #704 also contained a discussion of the risk and benefits for Aricept and there was also a review of side effect screens and the QDRR. There was discussion about the benefits of Aricept vs. other cholinesterase inhibitors and possible polypharmacy with more than one agent. Participants signed the statement that quarterly review had taken place, including for risk and benefit of the medication. The Monitoring Team found that the discussion identified the relevant risks and benefits and that sufficient and up to date information had been presented so as to make the evaluation meaningful and substantive. The PMOC meeting included a review of all individuals with intra-class polypharmacy. The meeting was necessarily fast-paced but key references were made to the presence or absence of side effects; for each individual reviewed there was a one paragraph summary of information that included the rationale and justification for the medication that allowed the inquiries of committee members to be focused and meaningful. Materials for the ISP for Individual #19 included medication plans for two psychotropics taken by the individual. The medications were from different classes so the individual did not have intra-class polypharmacy.	

The neuropsychiatry conference attended by the Monitoring Team is presented under Provision J15. The conference between the psychiatrist and neurologist focused on anticonvulsant medications administered for both psychiatric and neurological indications. For each individual the rationale and ongoing need for each medication were reviewed, labs and any side effects were discussed, and plans for continued administration (and when appropriate, treatment alternatives) were reviewed.

Overall, the Monitoring Team observation during the visit confirmed that good quality processes were in place to review medication risk and benefit at the point of service (PMR and neurology clinics), individual review (ISP conference) and Facility-wide review and oversight (PMOC).

<u>Documentation of Risk Benefit Assessment and Alternative Treatments for New Medications</u>
The Monitoring Team reviewed all 30 new medications proposed by the Facility during the review period that constituted Sample J3.

Information about the new medication was contained (1) in the most recent PMR note for IDT discussion, (2) in the MP, for information about medication name, psychiatric diagnosis relevant to the diagnosis, the rationale for the use of the medication, the psychiatric target symptoms for medication treatment, and risk benefit determination, and (3) the informed consent document, for information about specific side effects of the medication pertinent to the individual, participation in the IDT deliberations by the nurse case manager, and PCP participation in the IDT.

Information on treatment alternatives was contained (1) in the most recent PMR note for IDT discussion, (2) in the MP in sections on rationale, on alternative psychotropic medication treatments considered (and why) and in the section on adjunctive treatments in place or suggested. Additional information was obtained from (3) the PBSP, regarding environmental and programming supports, individual therapy (cognitive behavior/supportive), group therapy, communication therapy, and others therapies such as sensory integration therapy, sleep hygiene, social skills training, etc.

Results were as follows:

Element	Was needed information contained documents provided?	Monitoring Team's assessment
Psychiatric diagnosis for the medication	30 of 30 (100%)	DSM diagnosis present in 30 of 30 (100%)
Rationale for the use of	29 of 30 (100%)	Reasonable rationale

medication		provided for 29 of 30 (96%)
Psychiatric target symptoms for the treatment	30 of 30 (100%)	Reasonable psychiatric symptoms for treatment identified for 29 of 30 (96%) of the medications
Documentation of risk benefit discussion	30 of 30 (100%)	Adequate presentation provided for 27 of 30 (90%) of the medications
Documentation of nurse case manger participation in IDT deliberations	30 of 30 (100%)	Present for 30 of 30 (100%) of the medications
Documentation of participation of the PCP in IDT deliberations (typically via telephonic contact with the psychiatrist)	30 of 30 (100%)	Documentation adequate in 30 of 30 (100%) of the medications
Documentation of participation of the psychiatrist in IDT deliberations	30 of 30 (100%)	Documentation adequate for 30 of 30 (100%) of the medications
Documentation of specific medication side effects pertinent to the individual	30 of 30 (100%)	Documentation adequate for 30 of 30 (100%) of the medications
Documentation of possible alternative treatments	30 of 30 (100%)	Documentation adequate for 28 of 30 (93%) of the medications

HRC Review of New Medications

In the Self-Assessment the Facility reported timely HRC reviews for non-emergency psychotropic medications have been in place since the psychiatry department implemented a new HRC review procedure in April, 2013. As described in more detail under Provision J14, the Monitoring Team found adequate and timely HRC review of six new medications reviewed under the new procedures. Timely HRC review was not in place for most of the review period and HRC review documents were not provided to the Monitoring Team for 21 of 30 (70%) of new medications proposed during the review period.

Monitoring Team's Compliance Rating

The provision required the IDT, including the psychiatrist, primary care physician, and

		nurse, to compare the harmful effects of the individual's mental illness with possible harmful effects of psychotropics and to evaluate alternative treatment strategies. The Monitoring Team observed that good quality processes are in place. The Monitoring Team confirmed documentation of the process via review of all new medications proposed for use during the review period. All requirements were met in at least 90% of the cases. The final stage in the Facility process is HRC of the new medication for various elements, including the IDT's determination that the risks of the harmful effects of the mental illness are greater than the risks of possible medication side effects. That was not in place for many medications started during the review period. In order to obtain substantial compliance status for this provision timely HRC reviews must be provided consistently.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The Facility reported to the Monitoring Team that, as of 06/01/13, 248 of 484 (51%) of the individuals who lived at the Facility received support from psychiatry, including psychotropic medication. Of note, PMOC reports that follow also include information from June 2013. Review of those individuals who took psychotropic medication showed that 16 of 248 (6.4%) received two or more psychotropic medications from the same clinical class, e.g. two antipsychotics. For the purposes of the SA, that was considered to be psychiatric intraclass polypharmacy. Another form of psychiatric polypharmacy was when individuals received a total of three or more psychotropic medications. Fifty-five of 248 (22%) individuals took three prescribed psychotropics. <u>Facility Level Review System:</u> 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 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 polypharmacy (three, four, or five psychotropics medications) were also reviewed, as were individuals taking certain classes of medications (benzodiazepines, anticonvulsants, anticholinergics and so forth). Use of anticholinergics and medications for cognitive decline were also reviewed. The Monitoring Team attended the monthly PMOC. The meetings were well structured and meetings were attended by 20 individuals or more. <u>Polypharmacy Data:</u> For interclass and intraclass polypharmacy, data were as follows:	Substantial Compliance

Reduction of Polypharmacy	Dec 2008	Dec 2009	Dec 2010	Dec 2011	Dec 2012	June 2013
Prescribed intraclass	24	21	18	12	16	16
Prescribed psychotropics: 3	56	53	50	46	51	55
Prescribed psychotropics: 4	34	26	17	15	10	12
Prescribed psychotropics: 5+	13	8	5	2	0	0

(*) Since Feb 2012 the count includes all medication for Alzheimer's disease and medication with dual purpose (neurology and psychiatry)
(**) 13 new admissions to the Facility between October 2012 and June 2013. Four individuals were admitted to the Facility with intraclass polypharmacy and five individuals were taking three or more psychotropic medications

The above data is consistent with a continued decline in the use of polypharmacy at the Facility, when recent admissions are considered.

During the review period the Facility introduced a reporting method in which individuals with polypharmacy were reported in three groupings – new admissions in the past 12 months, individuals with intraclass polypharmacy going through a medication taper, and individuals with stable intraclass polypharmacy. This differentiation was very helpful as each group represents a difficult set of circumstances that effect the evaluation of the polypharmacy: Thus, individuals admitted from the community were often the recipients of polypharmacy. For such individuals it was often clinically appropriate to undergo a period of acclimatization to the Facility and for Facility staff to get to know the individuals and to learn more about both the individual and the underlying needs that may have lead to the polypharmacy. For individuals designated as in the process of a medication taper, the questions posed by the committee might focus on the strategies used to safely undertake that taper. Individuals deemed by the Facility as stable – and presumably justified - might receive additional scrutiny to examine whether that assertion was clinically justified. The inclusion of the data on each individual's circumstances facilitated an open and transparent analysis of the individual's medication regimen and it was a positive development.

<u>Polypharmacy Justifications</u>
Monthly review of individuals with intraclass antipsychotic polypharmacy continued. Presentation of the circumstances of individuals for whom higher risk polypharmacy (for example intraclass antipsychotic polypharmacy in Individual #386) was sufficiently

		detailed to allowed meaningful evaluation to be made about the need for the medications. <u>Monitoring Team's Compliance Ratings</u> The process of Facility-wide monitoring of psychotropic medication use generally, and polypharmacy reduction in particular, has become better established and more routine. There was an effective balance of input from departmental databases (e.g. pharmacy) and analyses of individual cases (e.g. individual polypharmacy justifications). While the focus is properly on polypharmacy, the committee meetings continued to be an excellent venue for integrated analyses of medication related issues such as tardive dyskinesia, metabolic syndrome and other medication side effects. Broad interdepartmental participation including medicine, psychiatry, pharmacy, nursing, QA and others ensured sharing of highly relevant medication related clinical information. The Facility was already in substantial compliance with this provision of the SA and that finding is unchanged.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	<u>Policy and Procedure:</u> DADS Policy 007.3 Psychiatric Services (05/01/2103) addressed the matter of side effect screening. The policy clarified that the nursing staff must pass competency based training annually prior to completing the DISCUS and MOSES evaluations, that these must be completed every three and six months respectively, and that the psychiatrist needed to review the results of the scale within seven working days of completion of the screen. The policy clarified that side effect screen may also be done within 30 days of a medication dose change, as determined clinically necessary by the psychiatrist. <u>Process in Place for Side Effect Screening</u> The system in place for side effect monitoring at the Facility was for side effect screening with MOSES to be done every six months and DISCUS examinations to be done on a quarterly basis. The examinations were done by each individual's nurse case manager. 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). MOSES and/or DISCUS examinations were also done following a psychotropic medication change, as determined clinically necessary by the psychiatrist. Side effect screens were also reviewed during PMRs and were part of the data from other IDT activities such as ISP meeting, IRRF evaluations and neuropsychiatry reviews. Facility-wide reviews took place at PMOC (see Provision J11 regarding the review for tardive dyskinesia during the May PMOC). <u>Quality of IDT Discussions about Side Effects</u> During the visit, the Monitoring Team observed discussion about side effects during two PMRs, a PMOC meeting, an ISP conference, and a neuropsychiatry conference.	Substantial Compliance

		1. PMR meetings: The Monitoring Team attended PMRs on 07/23/13 for Individuals #204 and #704 and observed how information about side effects was discussed by IDT members. Information about side effect screening was presented by the nurse during the part of the discussion that was dedicated to objective medical data and review of that data. That section also included information from the pharmacy provided via the QDRRs. Information presented included laboratory data, drug/drug interactions, and pharmacy recommendations for clinical information that were derived from that data. The discussion for Individual #204 included a detailed discussion between the psychiatrist and nurse about current and past side effects of Zyprexa, MOSES and DISCUS side effect screens that were reviewed, and there was an active discussion about appropriate management given the individual's diagnosis of tardive dyskinesia but currently low ratings on the DISCUS. The psychiatrist decided to increase the dose of Zyprexa and requested an additional administration of side effects screens following the change in diagnosis. The quarterly PMR review of Individual #704 also contained a review of MOSES related to the Individual's treatment with Aricept. The Monitoring Team found that the discussion identified the relevant risks and benefits and that sufficient and up to date information had been presented so as to make the evaluation meaningful and substantive. 2. ISP conference: The Monitoring Team attended the ISP meeting for Individual #19 on 07/23/13. The ISP conference identified that the individual had multiple medical problems including dysphagia and diabetes but these were not exacerbated by the psychiatric medications. The IRRF reviewed those medical problems but again these did not appear to have been side effects of medications. 3. PMOC meeting: The Monitoring Team attended the PMOC meeting on 07/23/13. The main focus of the discussion was a monthly review of intraclass polypharmacy. The individual-by-individual review was facilitated by summaries of individuals and their current status. Side effect information and status was integrated into those summaries in an integrated and meaningful way. Examples included Individuals: #791 (tardive dyskinesia and metabolic syndrome), #379 (anticholinergic load), #255 (QTc prolongation) and #620 (doxepin and itching). PMOC also served as a place for focused Facility level review of individuals with tardive dyskinesia, most recently in May 2013 (see further discussion under Provision J11). 4. Neuropsychiatry conference: The Monitoring Team attended a conference of the psychiatrist and neurologist at the neurology clinic, as described in more detail under Provision J15. The conference included discussions about side effects, for example for Individual #335, as it related to the Individual's difficulty with drooling. Overall, the Monitoring Team observation during the visit confirmed that good quality processes were in place to review medication risk and benefit at the point of service (PMR and neurology clinics), individual review (ISP conference) and Facility-wide review and oversight (PMOC).	

Individual Case Reviews:
The Monitoring Team reviewed MOSES and DISCUS since the last visit for all 24 individuals in Sample J6.

MOSES Examinations
A total of 58 administrations of MOSES for individuals in Sample J6 were provided to the Monitoring Team

Administered at least once every six months	24/24 (100%)
Signed by physician	54/58 (93%)
Signed timely	48/58 (82%)
Physician completion of examination sections for comments about examination results	52/58 (89%)
Additional administration of MOSES in response to change in dose or clinical circumstances requiring added monitoring	34 (*)

(*) Additional screens were typically done in response to changing clinical conditions. In some cases IPNs and PMRs did not clarify the reason and it appeared to the Monitoring Team that on some homes MOSES examinations were administered quarterly on a routine basis rather than every six months.

DISCUS Examinations
Seventeen of the 24 individuals in Sample J6 took medications that required screening with DISCUS. DISCUS results were received for 15 of 17 (88%) of those individuals. DISCUS examinations were not received for Individuals #152 and #628. However, the Monitoring Team was able to review a nursing spreadsheet which provided dates on which individuals had received MOSES and DISCUS examinations across the campus. According to the spreadsheet, Individuals #628 and #152 had received the screenings at the required intervals. Individual #152 also had an additional administration.

For the 15 individuals for whom DISCIS forms were submitted, there were a total of 28 administrations of the DISCUS

Completed at least every three months	15/15 (100%)

Signed by physician	27/28 (96%)
Signed timely	26/28 (92%)
Physician completion of examination sections for comments about examination results	22/28 (79%)
Additional administration of DISCUS in response to change in dose or clinical circumstances requiring added monitoring	13/15 (86%)

Monitoring for Metabolic Syndrome

Unlike the DISCUS examination for tardive dyskinesia, there is no standard assessment tool for monitoring, detecting, reporting and responding to the presence of metabolic syndrome, a condition that involves changes in weight/abdominal girth, abnormalities in glucose and lipid metabolism. The syndrome is associated with administration of medications, including psychiatric medications such as atypical antipsychotics. The Facility has introduced a protocol for case-by-case monitoring of individuals for the presence of metabolic syndrome. One of the principal places for review of results for the possible presence of metabolic syndrome was the PMR that was attended by the psychiatrist and nurse case manager, and during which QDRRs were reviewed. The Monitoring Team noted that metabolic syndrome screening was reviewed during PMRs for Individuals #204 and #704. Metabolic syndrome monitoring was also a focus of the psychotropic medication committee.

DISCUS Monitoring for Individuals taking Metoclopramide

Metoclopramide is a medication used for gastrointestinal indications but is structurally related to antipsychotics and like them, can produce movement problems including tardive dyskinesia. In DADS Policy and Procedure 007.3 Psychiatry Services (05/01/13) metoclopramide is listed as one of the medications that required DISCUS evaluations every three months. There were 41 individuals at the Facility who took metoclopramide. Seven of 41 (17%) were followed by psychiatry and all seven (100%) received DISCUS screenings every three months. Thirty-four of 41 (83%) took no medications for psychiatric indications and were not seen in the PMR clinics. Facility nursing tracking sheets showed that 29 of 34 (85%) had received DISCUS screening every three months. None rated positive for dyskinesia.

Facility level review of Individuals who had Tardive Dyskinesia

Four individuals were diagnosed with tardive dyskinesia. All were followed by psychiatry. The pathophysiology of tardive dyskinesia is such that the same medications that cause dyskinesia can also mask the effects, and thus lower DISCUS ratings. For that reason when those medications are reduced, for example during efforts to minimize

		unnecessary polypharmacy, DISCUS scores may actually go up rather than down. Review of PTR documents of individuals from Sample J1 who had dyskinesia showed that psychiatrists were attentive to that issue. Further comments about PMOC monitoring for dyskinesia were included under Provision J11. 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. Review of all individuals who had dyskinesia was part of the work of the PMOC (see Provision J11). <u>Training for Administration of the MOSES and DISCUS side effect screens:</u> During the visit the Monitoring Team met with representatives of the Nursing Department to review QA for side effect screening, including the training that 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 trainings 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 was facilitated by videotape and written materials prepared by the author. The Monitoring Team confirmed that nurse case managers attend annual re-training on the administration of the side effects tools. According to the Nurse Education Department 29 of 31 (94%) nurse case managers participated in the annual refresher training for MOSES and DISCUS administration in January 2013. <u>Monitoring Team compliance ratings:</u> The Facility has a good system in place to monitor side effects of psychotropic medications. Administration of the DISCUS and MOSES screens was done by nurses who received good training on the tools and who received annual re-training to assure continued competence. Physicians received the screens for review in a timely manner after administration so that needed changes could be made, and the screen results were then additionally reviewed at PMR appointments. Facility level review was in place at the Facility. The administration of side effect screening was by nurse case managers who were familiar with the individuals, and they received good initial training and annual refresher training on the administration of MOSES and DISCUS examinations. Reviews of the results of the screens and their implications for psychotropic medication management were well integrated into individuals PMR reviews and into broader treatment reviews such as ISPs and neuropsychiatry conferences. POMC provided Facility level review for tardive dyskinesia and metabolic screening monitoring. The Facility provided side effect screen as required by the provision and is found to be in substantial compliance with the requirements of this provision.	

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.	<u>Facility Procedure</u> 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. <u>Medication Plan information</u> The sections of the MP remained: • Name of the medication • Psychiatric Diagnosis • Rationale for treatment • Target psychiatric symptoms • Symptoms to be monitored • Timeline for expected results • Risk/Benefit Assessment • Treatment Alternatives The Monitoring Team reviewed all new psychotropic medication initiated during the review period. There were 30 such medications for 18 individuals. These were Sample J3. Findings were as follows: • <u>Name of the medication and psychiatric diagnosis:</u> MPs contained both the name of the medication and the individual's psychiatric diagnosis or diagnoses in 30 of 30 (100%) of the MPs • <u>Rationale for the treatment:</u> 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 29 of 30 (96%) of the MPs • <u>Target psychiatric symptoms:</u> 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. These were present in 29 of 30 (96%) of the MPs • <u>Symptoms to be monitored:</u> 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. These were defined in the PBSP addenda described above. They were available for 6/30 (24%) of MPs. • Timeline for expected results was present in 30/30 (100%) of the MPs • Risk/Benefit Assessment was present in 30/30 (100%) of the MPs • Treatment Alternatives: Adequate information and analysis was present in 28/30 (93%) of MPs	Noncompliance

		Quality of Monitoring for Treatment Efficacy: The Monitoring Team observed two PMRs, on 07/23/13 with Dr. Salam and on 7/23/13 with Dr. Hardin. As described under Provision J2 and J3, PMR meetings included key members of the IDT and they were a venue that generated good clinical discussions between psychiatrists, key IDT members, and when needed, the LAR and others. As a result, it was an excellent setting in which to make decisions about medication management. However, decision making was rarely informed by good presentations and analysis of behavioral data. For example, in the Self-Assessment the Facility's reported that 25 of 248 (10%) records of individuals who received psychiatric medications (reported in the Facility Self-Assessment) showed that only 50% of the symptoms cited in MPs matched the psychiatric symptom tracking described in PBSPs. During the review period the Facility began implementation of an improved system for target psychiatric symptoms to be recorded and for appropriate tracking of psychiatric data to be put in place. To do so, IDTs began to generate PBSP addendum that included key psychiatric information. To date, PBSP addenda have been prepared for 63 of248 individuals (25%) of individuals followed by psychiatry. The process of updating the overall PBSP to include that information is ongoing. Amongst other things, the PBSP addendum format contained a page in which operational definitions were provided that specified exactly what would be measured and reported back to the psychiatrist PMR. As outlined in previous reports in sections J and K, identification of appropriate measures for psychiatric symptom tracking is only one of the improvements needed; also needed are improvements in graphic presentation of data so as to make graphs more informative. Elements such as baseline measures of rated symptoms and indicators of significant events were usually not included on graphs, and medications could be better displayed with informed selection of y axis scaling that is guided by information about typical dosage of the medication. Monitoring Team's Compliance Rating As outlined above, a critically needed system for monitoring efficacy of medication treatments is in the process of introduction. The progress is impressive but the process is in early stages. Continued development is critical and the matter of meaningful tracking for treatment efficacy is a key factor for compliance of many SA provisions. For now, the provision remains in noncompliance.	
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	Facility Policy DADS Policy and Procedure 007.03 Psychiatry Services (05/01/13) detailed that "before prescribing psychotropic medications to individuals and/or before significant changes in the individual's psychotropic medication regimen. The state center must provide information about the psychotropic medication to the individuals, their families, and/or their legally authorized representatives (LARs). The information must address	Noncompliance

	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.	characteristics of the medication, including expected benefits, potential adverse side effects, dosage, and standard alternative treatments; legal rights; and any questions the individual, the family and /or LAR may have." Additionally, the Policy and Procedure states that "the state centers must obtain informed consent (except in the case of emergency) prior to administering psychotropic medications or other restrictive procedures." <u>Current Procedures for Consent and HRC Review of Consent</u> During the current visit the Monitoring Team learned about new procedures that were put in place in the spring of 2013, to address problems previously noted regarding timely review of the consent by HRC. The Monitoring Team understood that difficulty in revising the overall PBSP prior to the HRC review had resulted in failures to have the review take place in a timely manner. New procedures are now in place under which the initial presentation to HRC will not require revision of the full PBSP prior to review of the medication by HRC. The Facility provided the Monitoring Team with a revised (effective 3/22/13) form for HRC review of psychotropic medication. The form provided check boxes for • Psychiatric case formulation and treatment plan • Psychotropic medication plan • Psychotropic medication consent form • Most recent PBSP These boxes clarify the information that is now provided to HRC for medication review and approval. Details of the planned behavioral tracking for efficacy of the medication would then be submitted to HRC within 30 days. The Facility reported that timely HRC reviews for non-emergency psychotropic medications have occurred since the psychiatry department implemented the new HRC review format on 4/08/2013. <u>Consent Form in Place at the Facility</u> The consent form currently in use at the Facility provided the following information: • Diagnosis • Medication for approval, medication dose, and route of administration • FDA recommended dose range • Pertinent side effects (discussed with guardian/director) The consent form had boxes for signature/date of the prescribing physician (which in all cases was the psychiatrist), the psychiatrist to document the date/time of the discussion between the psychiatrist and the primary care physician and the nurse case manager. When the psychiatrist initially obtained verbal consent, the consent was confirmed by two witnesses. The form was signed by the guardian (following the verbal consent, when the latter was needed) and reviewed/approved by HRC.	

		A general indication was provided on the form in which the (LAR) acknowledged that explanations about the medication were given in simple, nontechnical language and included: • A description of any benefits to be expected • Disclosure of any appropriate alternative procedures that might be advantageous to the person served as well as the potential risks and benefits associated with those alternatives • Possible adverse side effects/risk of the prescribed medication, per drug effect monographs provided <u>Medication Plans provided to LARs</u> LARs were provided with a copy of the MP that contained considerable information about the medication including information on: Each MP contained: • Name of the medication • Psychiatric Diagnosis • Rationale for treatment • Target psychiatric symptoms • Symptoms to be monitored • Timeline for expected results • Risk/Benefit Assessment • Treatment Alternatives <u>Monitoring Team Review</u> To assess compliance during the overall review period the Monitoring Team requested all non-emergency psychotropic medications started since the last visit. This was Sample J3 and consisted of 30 medications for 18 individuals. Of those, timely HRC review was provided for six of 30 (20%) of the medications. These six medication plans were reviewed by HRC between 03/13/13 and 06/05/13. <u>Monitoring Team's Compliance Rating</u> The Facility continued to focus on needed improvements in Facility procedures that would assure that new medication treatment plans and informed consent for those medications would be reviewed in a timely manner. At the time of the next visit the Monitoring Team will review the implementation of the new procedures for timely review of new and annual review of medication plan and consent.	
J15	Commencing within six months of the Effective Date hereof and with	Materials reviewed for assurance of compliance with Provision J15 included the list of dual purpose anticonvulsant medications used (1) for psychiatric indications, (2) for	Substantial Compliance

	full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	neurological indications, and (3) dual purpose medications used for both psychiatric and neurological indications. The Monitoring Team reviewed the ongoing functions of the neuropsychiatry clinic with the nurse who coordinated the neurology clinic. The overall structure for consultation between psychiatry and neurology had several layers. First, each month a one hour neurology-psychiatry conference was scheduled during the neurology clinic, which took place most Wednesday mornings. The conference was attended by a neurologist, a Facility psychiatrist, the nurse who coordinated the neurology clinic, and a psychiatrist assistant. A Facility psychiatrist attended on a rotating basis, so that over time all had the opportunity to review shared cases with a neurologist. As needs arose, psychiatrists also consulted with the neurologist during neurology clinic appointments for individuals, jointly supported by neurology and psychiatry and via as-needed consultations during the hours of the neurology clinic. This structure allowed psychiatrists to consult with the neurologist on a regular basis as needs arose. A neuropsychiatry conference was scheduled during the visit of the Monitoring Team and the Monitoring Team attended the conference. The Individuals reviewed were Individuals #4, #119, #299, #335, #533, and #776 (Sample J4). Each of these individuals received anticonvulsant medication(s) for both seizure control and a psychiatric indication. The Monitoring Team requested and was provided with the most recent PMR notes for each of the Individuals. • Individual #4 had been weaned off Dilantin and remained on Depakote as a dual-purpose medication. Depakote had been increased, blood levels were reviewed, and seizure and behavioral control issues were discussed. • Individual #119 has also been weaned off Dilantin and remained on Tegretol. That individual had long been considered for the presence of pseudo seizures and he had recently been hospitalized at a state hospital for behavioral issues. The phenomenology of the episodes in question was reviewed and both neurological and psychiatric medications were reviewed. • Individual #299 remained on Depakote for both neurological and psychiatric indications. A psychiatric medication had been tapered due to sedation, without any effects on seizure control. His overall status was reviewed; Depakote level and other blood tests were reviewed. • Individual #335 took Depakote as a dual-purpose medication. His physical status had been impaired by an elevated ammonia level and his progress on that matter was reviewed. • Individual #533 also took a dual-purpose medication. The individual had experienced some difficulties with drooling and possible drug interactions were reviewed. • Individual #776 had a change in Tegretol dose due to behavioral needs. Seizure	

		frequency, anticonvulsant levels and chemistry labs were reviewed, as were efforts to obtain an EEG, which had been difficult due to the individual's refusal to participate. Overall management for both psychiatric and neurological conditions was reviewed. The Monitoring Team reviewed the pharmacy tracking for anticonvulsant use which 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 individuals in Sample J4. The review showed that in both Neurology and Psychiatry Clinics the Physician and colleagues were aware that the medication was used for both purposes. Appropriate data such as drug levels and dose changes were collected and reported. MOSES reviews continued to be obtained 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. That was positive since sometimes behavioral effects become apparent only when the dose is changed. For that reason, it was very helpful that psychiatrists were aware of changes in anticonvulsant medication even when the medication is formally prescribed only for epilepsy. Taken together, the increased attention to tracking the behavioral effects of all anticonvulsant medications was positive, and was an example of well integrated care. On the basis of the discussion with the psychiatrists, the discussion with the clinic coordinator, and review of the relevant documents, the Monitoring Team found that coordination between psychiatry and neurology remained strong, and DSSLC remained in compliance with the provision of the SA.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/2013 2. DSSLC Action Plan 6/21/2013 3. DSSLC Presentation Book for Section K 4. Positive Behavior Support Committee meeting minutes 12/05/2012 – 5/15/2013 5. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the Self-Assessment and included Individuals #68, #110, #119, #240, #259, #276, #581, #632, #718, #721, #735, #772, #778, and #781. **People Interviewed:** 1. Randy Spence, MS – Director of Behavior Services 2. Katy Acheson, MS, BCBA – Contract Psychologist 3. Ira Adams, PhD – Psychologist 4. Laura Dittlinger-Harper, BCBA - Consultant **5.** Approximately 20 direct care staff in the following residences and day treatment areas: Residence 508A, 508C, 523A, 523D, 525A, 527A, 527C, 528B, and 528D, as well as vocational settings ICD120, ICD121, ICD124, and ICD128 **Meeting Attended/Observations:** 1. Positive Behavior Support Committee 2. The following residences and day treatment areas: Residence 508A, 508C, 523A, 523D, 525A, 527A, 527C, 528B, and 528D, as well as vocational settings ICD120, ICD121, ICD124, and ICD128.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. 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. At the time of the site visit, DSSLC reported in the Self-Assessment that Provisions K.2, K.3, K.5, K.8, and K.13 were in substantial compliance with the Settlement Agreement. The Monitoring Team was in agreement with the Facility concerning Provisions K.2, K.3, and K.8. Regarding Provision K.5, the Monitoring Team found a lack of consistent integration of psychology and psychiatry, as well as a lack of current assessments of adaptive skills. In Provision K.13, although the Facility had achieved considerable progress, it had not achieved a ratio of one BCBA for every 30 people living at the Facility. For Section K, in conducting its self-assessment: ▪ The Facility did not report the use monitoring/auditing tools. The Facility did report the materials

	or procedures that were reviewed, often with substantial detail. The Self-Assessment did not, however, indicate the tools used in the monitoring/auditing process. ▪ The Facility did use other relevant data sources, such as BCBA certification tracking information, internal and external peer review results, individual All About Me books, PBSP data sheets, assessment tracking data, and staff training summaries, ▪ The Facility did present information about all provisions. Without clear indications of what tools and procedures were used, it was at times difficult to determine the utility or accuracy of the information. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Complete, In Process, and Not Started. No particular patterns were noted in the status of elements. ▪ The Facility data identified areas of need/improvement. In many circumstances, however, the Action Plans did not indicate the specific actions to be taken. In addition, the action steps focused upon establishing processes or developing tools rather than focusing upon qualitative enhancements.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at DSSLC from 7/22/2013 through 7/26/2013. 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 built upon previous achievements and continued to make progress; at times, that progress was considerable. It also appeared that the Facility was working toward substantial compliance in a systematic and coherent manner. Although an extensive amount of work remained, it was suggested that current processes were effective. Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved. • All Behavioral Services staff had obtained Board Certification as a behavior analyst or were actively pursuing certification. • The PBSP data was precise, well organized and adequate for assessing the effects of behavior interventions. • Assessment of environmentally based behavior had improved across many elements. • The provision of counseling services was sophisticated, evidence based, and targeted toward the unique needs of each individual served. • Previously noted delays in reviewing, approving and implementing PBSPs were substantially shorter. • PBSPs continued to evidence sophistication and met conditions for compliance across several areas measured. Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of

	progress in several areas. • Although the testing of adaptive skills had substantially increased, efforts did not ensure that all individuals were provided with current assessments. • The Facility continued to experience difficulty in ensuring that intervention data were reliable. • DSP staff continued to demonstrate limited knowledge about PBSPs and implementation instructions. • Although in several examples there was adequate integration of behavior and psychiatric interventions, this quality was not consistently demonstrated across interventions for all individuals. Overall, DSSLC had demonstrated considerable effort toward achieving substantial compliance with the Settlement Agreement. Although several Provisions had not yet met substantial compliance, the effort demonstrated thus far had allowed the Facility to progress toward the goal of compliance.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K1</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td><u>Historical Perspective</u>
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 staff were BCBAs, an increase of 31%. In October 2012, only 42% of the Behavior Service staff possessed Board Certification.

<u>Current Site Visit</u>
During the current site visit, Facility records regarding Psychology Department staff were reviewed. These records reflected that 11 of 19 staff (58%) were board certified as a behavior analyst. Of the remaining eight staff, eight (100%) were actively pursuing board certification. Therefore, it was determined that 100% of the current Psychology Department staff either possessed or were actively pursuing board certification.

<table>
<tr><td></td><td>3/2010</td><td>10/2012</td><td>7/2013</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>24%</td><td>42%</td><td>58%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>23%</td><td>64%</td><td>100%</td></tr>
<tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>50%</td><td>79%</td><td>100%</td></tr>
</table>

Documentation obtained during the site visit reflected that the Behavior Services department at DSSLC was aggressively pursuing Board Certification for all eligible staff. The Facility had demonstrated consistent effort to increase the number of staff possessing Board Certification, and all staff currently either possessed or were engaged in obtaining Board Certification.</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>K2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.</td><td>At the time of the site visit, DSSLC employed a full-time director of Behavior Services, Joseph Randall Spence. Mr. Spence had extensive experience in the field of intellectual and developmental disabilities. In January 2012, Mr. Spence Mr. Spence passed the exam for board certification in applied behavior analysis. This accomplishment by Mr. Spence satisfied the Provision K2 requirements for substantial compliance with the Settlement Agreement.</td><td>Substantial Compliance</td></tr>
<tr><td>K3</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.</td><td>DSSLC, at the time of the current site visit, continued to implement the internal and external peer review process noted during previous visits. The internal peer review committee was coordinated by the Behavioral Services staff members who are board certified as behavior analysts. A review of committee minutes and discussions with staff revealed active application of a peer review model that was sound and met expectations.

External peer review was performed by Ed Hutchison, PhD, BCBA. Dr. Hutchison reviewed 100% of PBSPs submitted for internal peer review by the PBSC. Submissions were reviewed on a monthly basis and returned to the PBSC prior to the date scheduled for internal peer review. PBSPs reviewed by Dr. Hutchison were rated on a checklist. Feedback was provided to the submitting psychologist in the forms of checklist scores, written comments, and recommendations. In addition, Dr. Hutchison also attended the PBSC meetings frequently to provide additional verbal feedback.

External peer review included the use of a checklist that targeted 8 areas of competence: 1) Individual is fully described or identified, 2) Rationale for Positive Behavior Support, 3) Goal/Objective, 4) Functional Assessment, 5) Written PBSP, 6) Plan of Implementation, 7) Program Evaluation, and 8) Professional Integrity. Items in each of these areas were rated on a scale of zero (no evidence the task was performed) to three (Best Practice competence). An aggregate comparison of all PBSPs receiving external peer review during the past six months with those completed during the first six months of the external peer review process is presented below.

<table>
<tr><th>Area of Competency</th><th>Percentage Achieved 9/2010</th><th>Percentage Achieved 10/2012</th><th>Percentage Achieved 7/2013</th></tr>
<tr><td>Competency 1</td><td>78</td><td>98</td><td>100</td></tr>
<tr><td>Competency 2</td><td>50</td><td>88</td><td>96</td></tr>
<tr><td>Competency 3</td><td>75</td><td>92</td><td>98</td></tr>
<tr><td>Competency 4</td><td>52</td><td>97</td><td>98</td></tr>
<tr><td>Competency 5</td><td>51</td><td>89</td><td>98</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Competency 6</td><td>35</td><td>100</td><td>100</td></tr>
<tr><td>Competency 7</td><td>33</td><td>96</td><td>99</td></tr>
<tr><td>Competency 8</td><td>78</td><td>96</td><td>99</td></tr>
<tr><td>Total of all Competencies</td><td>55</td><td>94</td><td>98</td></tr>
</table>

Based upon this comparison, training and review practices had been enhanced, and behavior assessments and interventions were improved. Although there were areas in which the PBSPs did not yet meet substantial compliance with the SA, the peer review process was effective in improving the PBSPs. Based upon the data obtained during the most recent site visit; peer review was successful in meeting substantial compliance with the SA.</td><td></td></tr>
<tr><td>K4</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td><u>Historical Perspective</u>
Considerable deficits were noted in the collection of behavior data during the initial site visits. Total frequency data collection remained the most common method for measuring behavior. Staff reported, and observations and progress notes supported, that at times it was difficult to collect data as indicated in the PBSP.

In February of 2011, a new data collection system was implemented that used a standard form for recording data. This form was designed to accommodate frequency counts, as well as duration, interval and accuracy measures. In September 2011, observations and record reviews revealed substantial improvement in many areas over the baseline site visit. One area where data collection reflected substantial limitations, however, was in the graphic presentation of interobserver agreement (IOA) data. None of the data graphs reviewed included IOA data.

During the 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. Based upon a review of the eight available records, 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.

The October 2012 site visit reflected that DSSLC had achieved improvement in data collection regarding behaviors targeted for reduction, data graphs, and the assessment of individual target behaviors.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Current Site Visit During the current site visit, a sample of 14 individuals were selected for the review data collection and treatment monitoring. These individuals included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #68, #110, #119, #240, #259, #276, #581, #632, #718, #721, #735, #772, #778, and #781. The table below reflects the results from the current site visit review regarding the collection and presentation of data.	

	Baseline	10/2012	7/2013
Targeted behavior data collection sufficient to assess progress	0%	89%	100%
Replacement behavior data collection sufficient to assess progress	0%	44%	100%
Data reliability is assessed	0%	0%	71%
Target behaviors analyzed individually	0%	100%	93%
Targeted behaviors graphed sufficient for decision-making	60%	89%	86%
Replacement behaviors graphed sufficient for decision-making	0%	44%	86%

Information gained from the record sample reflected that DSSLC had achieved substantial improvement in four of the six areas (67%). In the remaining two areas, a modest decline in scores was noted. In both of these areas, the decline appeared due to isolated circumstances. For example, the graphing of target behavior dropped from 89% to 86% because of two individuals for whom the data graphs included ambiguous labels or inappropriate scales.

Other than the isolated weaknesses, the collection and presentation of treatment data at DSSLC was precise, well organized, and adequate to the task of monitoring the response to interventions. The system for recording data and compiling graphs was based upon a sophisticated spreadsheet using Microsoft Excel. It was evident that the continued improvements in the collection and presentation of treatment data was due in large part to the implementation of this system.

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

#	Provision	Assessment of Status	Compliance
		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, submitted documentation did not reflect that the Facility had developed the practices necessary to ensure that all individuals received effective interventions.	

	1/2010	10/2012	7/2013
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%	44%	21%
Input from direct care staff is solicited and documented	0%	0%	29%
Modifications to the PBSP reflect data-based decisions	0%	78%	71%
Criteria for revision are included in the PBSP	0%	100%	100%
Progress evident, or program modified in timely manner (3 Months)	0%	89%	79%

DSSLC demonstrated continued success 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 three of the 14 (21%) PBSPs in the sample. This reflected an improvement over baseline, but was less than half of the success noted during the previous site visit. This decrease was surprising in consideration of the increased number of BCBAs employed by the Facility.

Input from direct care staff

In four of the 14 records (29%), there was documentation that direct care staff were offered the opportunity or participated in the review of treatment data. Although this was an improvement over the previous site visit, it suggested that the DSP employees

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>continued to lack a voice in the provision of behavior interventions. In the four records where DSP input was documented, the information was included in the narrative portion of the progress note. It is recommended that DSSLC provide a mechanism to ensure that all PBSP progress notes include some feedback or input from the relevant DSP staff.

It was evident during the site visit that substantial effort had been made to improve behavior data and the use of data in the treatment monitoring process. Although these efforts had provided for substantial progress in several areas, the Facility continued to demonstrate some limitations in ensuring that all behavior data were presented and used in a satisfactory manner.</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td><u>Intellectual and Adaptive Assessment</u>
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, as well as how those abilities and limitations are manifested in the person's daily activities.

<u>Historical Perspective</u>
Through the September 2011 site visit, DSSLC had demonstrated minimal changes in the provision of testing of intellectual ability and adaptive skills in comparison with the baseline site visit; The September 2011 sample reflected that there was 0% compliance. In April of 2012, the Facility demonstrated a substantial increase in the number of Psychological Assessment reports. None of the reports reviewed, however, included current assessments of intellectual ability or adaptive skills. In October 2012, issues with documentation prevented an assessment of the Psychological Evaluation reports and the testing of intellectual ability and adaptive skills.

<u>Current Site Visit</u>
At the time of the current site visit, 10 Psychological Evaluation reports were submitted for review. The table below includes the findings of that review.

<table><tr><td></td><td>3/2010</td><td>4/2012</td><td>7/2013</td></tr><tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>4%</td><td>100%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

The Psychological Assessment was less than one year old	0%	4%	50%
The Psychological Assessments contained findings from an intellectual test administered within the previous five years.	0%	0%	80%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	9%	0%	100%

Based upon the findings of the review, it was apparent that DSSLC had achieved meaningful progress in ensuring that Psychological Evaluation reports contained the necessary test results. It should be noted that the two reports that did not include current testing of intellectual ability reported that testing had been attempted but could not be completed due to a lack of response from the individuals being tested. From a practical perspective, these two cases could be considered as having included intellectual testing, increasing the rating for this item to 100%.

In addition to providing intellectual and adaptive assessments, it is crucial that the findings of those assessments be presented in a manner that goes beyond the reiteration of scores and facilitates the identification of personal strengths and limitations. A sample of 10 records was selected to determine the degree to which this was achieved.

	1/2010	4/2012	7/2013
Psychological Assessments included a narrative summary of how the results from intellectual assessments would facilitate the understanding of the individual's strengths and needs.	0%	0%	80%
Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual's strengths and needs.	0%	11%	100%

As discussed in concern to the testing provided, the percentage for the narrative regarding intellectual test results was suppressed by two individuals who were unable to participate in the testing. Based upon the information obtained, it was evident that the Psychological Evaluation reports included pertinent and functional information about each individual that could be used in the development of skill acquisition training.

#	Provision	Assessment of Status	Compliance
		It should be noted that Provision K.5 pertains to the implementation of procedures that ensure the identification of, among other things, other psychological needs that may require intervention. To fulfill this obligation, it is necessary to provide current assessments. As discussed in Provision K.6 below, there were substantial limitations in ensuring that assessments were current. Specifically, although numerous assessments had been provided, none reflected the updates necessary for the findings to be considered current. <u>Behavior Assessment</u> 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. <u>Historical Perspective</u> 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. In October 2012, based upon a review of the 18 functional assessments, it was evident that considerable improvement had been achieved and maintained by DSSLC. The format for functional assessments was expanded and allowed for a more comprehensive presentation of findings. <u>Current Site Visit</u> During the current site visit, a sample of 19 Psychological/Functional Assessment reports was selected from those completed since the last site visit. The results from the review of those records is presented below.	

#	Provision	Assessment of Status	Compliance

	1/2010	10/2012	7/2013
Assessment or review of biological, physical, and medical status	0%	94%	95%
Review of personal history	0%	100%	95%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	89%	95%
The process or tool utilizes both direct and indirect measures	0%	83%	100%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	83%	95%
Identification of antecedents relevant to the undesired behavior	0%	83%	95%
Identification of consequences relevant to the undesired behavior	0%	89%	95%
Identification of functions relevant to the undesired behavior	0%	83%	95%
Summary statement identifying the variable or variables maintaining the target behavior	0%	89%	100%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	72%	100%
Identification of preferences and reinforcers	0%	83%	100%

Based upon the information obtained, it was evident that DSSLC had continued to build upon previous achievements. The assessments consistently reflected consideration of physical, medical, and environmental factors that could contribute to the display of undesired behavior. The functional assessment process included all elements required by accepted practices in applied behavior analysis. Overall, DSSLC consistently demonstrated a sophisticated and comprehensive approach to investigating the causes of environmentally based behavioral challenges.

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

#	Provision	Assessment of Status	Compliance
		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. 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 in 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. 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. In the review conducted in October 2012, 18 assessment reports reflected that the integration of mental health issues into the functional assessment, although much improved, did not consistently meet expectations. During the current site visit, a sample of 19 Psychological/Functional Assessment reports revealed the following about the integration of mental illness and behavior assessment.

	3/2010	10/2012	7/2013
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	94%	100%
The assessment process included differentiation between learned and biologically based behaviors.	0%	74%	74%
Identification of behavioral indices of psychopathology	0%	74%	74%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	94%	84%

As pointed out in this Provision, as well as in Section J of this report, DSSLC had achieved commendable progress in relation to the integration of psychiatric and behavior supports. In Section J, it is discussed that in 11 of 15 (73%) of reviewed PBSPs there was, "a genuine effort to describe how IDT members understood which behaviors were the

#	Provision	Assessment of Status	Compliance
		result of psychopathology and which reflect learned behaviors". The tables above reflects that 14 of 18 reviewed Psychological/Functional Assessment reports included a careful consideration of both environmental and mental illness issues regarding undesired behavior. In several reports, the Facility had assessed behavioral correlates of mental illness using anecdotal functional assessment tools such as the Motivational Assessment Scale (MAS) and the Questions About Behavioral Function – Mental Illness (QABF-MI). This reflected a considerable advance over previous practices. A critical weakness found during the current site visit, however, was a lack of consistency in the application of these practices. In five of 19 Psychological/Functional Assessment reports (26%), the assessment process did not reflect the rigor found in the other 15 assessments. • For Individual #285, the psychiatrist described self-injurious slapping that was non-functional and driven in nature. A continuation of psychotropic medication was recommended, but the psychiatrist also requested further assessment by the behavior analyst. Following a functional assessment, the behavior analyst stated, "Problem behaviors are a function of socially mediated positive reinforcement and socially mediated negative reinforcement". Despite the contradiction between the psychiatric and behavioral assessments, no effort was documented to reconcile the differences and develop a coordinated treatment plan. • The Psychological/Functional Assessment report for Individual #632 included the following statement by the psychiatrist, "Neurochemical imbalance has contributed to his impulsivity, mood lability and stereotypic motor activity. Zyprexa and Tegretol are being used as mood stabilizers to control mood swings, anxiety/irritability, aggression etc. Tenex is being used to target hyperactivity and impulsivity but no official diagnosis of ADHD." The behavior analyst did not provide input regarding this assessment, and the report included a functional assessment that targeted only aggression. There was a section of the Psychological/Functional Assessment titled *Differentiation between Learned Problem Behaviors and Psychiatric Symptoms.* The five paragraphs in that section of the report included only what appeared to be instructions on how to complete that section. Observations and documentation reviewed as part of the current site visit revealed many areas of progress in relation to the assessment process. It is essential, however, that DSSLC focus upon ensuring that the practices developed are implemented consistently across the Facility.	
K6	Commencing within six months of	Based upon the information presented in Provision K5, the functional assessments	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>completed by the psychology staff were considerably improved over previous site visits.

Of greater concern was the issue ensuring that individuals were provided with current assessments of intellectual ability and adaptive skills. As noted in Provision K.5 above, half of the records submitted for review were completed at least a year prior to the site visit. This prompted a review of all intellectual and adaptive ability assessments completed at the Facility. The data used in conducting this review were drawn from the testing tracking spreadsheet provided by the DSSLC. Those data are summarized in the table below.

<table><tr><th></th><th>Evaluation Reports</th><th>Intelligence Testing</th><th>Adaptive Skill Testing</th></tr><tr><td>2011</td><td>4</td><td>5</td><td>1</td></tr><tr><td>2012</td><td>144</td><td>17</td><td>132</td></tr><tr><td>2013</td><td>149</td><td>10</td><td>232</td></tr></table>
These figures initially suggested that DSSLC had made substantial progress toward ensuring that all individuals were provided with current assessments. Due to the longer duration in which intellectual assessment results are considered current, the five people who were provided intellectual testing in 2011, as well as the 17 in 2012, were considered to have current assessments of intellectual ability. This was not true, however, for assessments of adaptive skills.

Between 1/1/2012 and 7/26/2012, according to tracking data provided by DSSLC, 133 individuals were provided testing of adaptive skills. To remain current, those same individuals would require adaptive skill testing again within one year. Tracking data revealed, however, that none of those 133 individuals (0%) had been provided follow-up testing within the next year. For the single individual who was provided adaptive testing in 2011, no additional adaptive testing had been completed in the following two years.

It was positive that DSSLC had increased testing of intellectual and adaptive abilities for people living at the Facility. It was unlikely, however, that testing would prove beneficial in the long-term if assessments were not part of an on-going strategy to ensure that all individuals were provided the necessary testing on a regular basis. It is recommended that DSSLC develop a strategy to ensure that the identified assessments are provided on a regular basis.</td><td></td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to</td><td>Provision K.6 discussed the lack of on-going assessments for all individuals living at the Facility. Tracking data provided by DSSLC also indicated that some limitations in assessment had also occurred for individuals recently admitted to the Facility.</td><td>Noncompliance</td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>
<table>
<tr><th></th><th>Baseline</th><th>4/2012</th><th>7/2013</th></tr>
<tr><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>0%</td><td>0%</td><td>77%</td></tr>
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Since the previous site visit, 13 individuals had been admitted to the Facility. Tracking data revealed the following details.
• Thirteen of 13 individuals (100%) had been provided an assessment of adaptive skills.
• One of 13 individuals (8%) had been provided an assessment of intellectual ability. There was no indication of the number of newly admitted individuals who required intellectual assessment.
• Ten of 13 individuals (77%) had assessments compiled and interpreted within a written assessment report.
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<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td><u>Historical Perspective</u>
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 goals and initial assessments lacked objective and measurable treatment expectations. In addition, counseling notes lacked specific data and were often subjective opinions of poorly defined behaviors.

At the time of the April 2012 site visit, DSSLC reported that 23 individuals were receiving counseling through the Behavior Services department at DSSLC. The entire process of providing counseling had been redesigned to reflect an evidence-based approach to intervention. In addition, counseling treatment plans 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 and compiled into monthly progress notes. The primary weaknesses involved a lack of failure criteria and generalization plans.

In October 2012, progress could not be assessed due to problems with the documents submitted by the Facility.</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Current Site Visit At the time of the current site visit, DSSLC submitted material on 15 individuals receiving in counseling services. This material, included treatment plans, counseling meeting minutes, and the latest treatment progress notes. Information obtained from the review of 15 records is presented in the table below.	

	1/2010	4/2012	7/2013
Needed services identified in the psychological assessment are implemented within 6 weeks of the assessment	0%	100%	100%
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)	0%	100%	100%
Services are goal directed with measurable objectives and treatment expectations	0%	100%	100%
Services reflect evidence-based practices	0%	100%	100%
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	0%	100%	100%
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	0%	0%	100%
Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate	0%	0%	100%
Service identified in ISP and, if	0%	100%	100%

#	Provision	Assessment of Status	Compliance

applicable, PBSP			
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	0%	100%	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	0%	100%	100%

Based upon the records provided by the Facility, which constituted 100% of individuals participating in counseling, it was evident that DSSLC had continued to improve the quality of counseling services. In April 2012, all counseling interventions had met compliance criteria for six of the eight areas in Provision K.8. That success was continued in all counseling interventions that were being implemented at the Facility at the time of the current site visit. In addition, where counseling plans lacked failure criteria and plans for generalization training in April 2012, all plans currently being implemented at DSSLC included both detailed plans for generalization, as well as specific failure criteria.

Overall, the counseling services provided by DSSLC were sophisticated, individualized, and evidence-based. It was also very positive that the staff responsible for developing and implementing counseling interventions had worked closely with BCBAs to ensure that counseling interventions and PBSPs were complementary. Some examples of well-developed counseling interventions are presented below.

- Individual #790 had been referred by the IDT for counseling services. The target selected by the IDT had been shaking hands. During the assessments for counseling, the individual reported that he had no problems shaking hands but did want to improve his eye contact with others. As the individual's request was supported by the assessment data and was relevant to the referral issue of social skills, counseling was revised to focus upon the skill emphasized by the individual.
- Individual #110 had been provided counseling services by at least two staff at the Facility, as well as a private therapist in the community. When attempting to determine the best source for counseling services for this individual, the IDT used the treatment data from counseling in combination with the individual's stated preference.
- Individual #79 was referred for counseling due to behavioral issues related to his psychosis. Due to the intensity of his symptoms of psychosis, it was determined that the individual lacked the ability to participate in counseling sessions. Rather than not offer counseling, staff identified specific behaviors that

#	Provision	Assessment of Status	Compliance
		if strengthened would allow the individual to successfully participate in counseling. The counseling treatment program was written to include specific reinforcement strategies to strengthen the identified behaviors. At the time of the site visit, the individual had demonstrated progress. Based upon the information obtained from records, interviews with staff, and observations, it was suggested that DSSLC had met criteria for substantial compliance concerning Provision K.8.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been 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.	<u>PBSP Approval and Consent</u> DSSLC reported that 96 PBSPs out of a sample of 96 PBSPs (100%) were completed prior to the Human Rights Committee review and had been approved by the Human Rights Committee. A sample of 10 PBSPs reviewed during the site visit reflected all were provided the necessary consents. 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 timely manner and if the necessary approvals were obtained for those behavior interventions. The documentation reflected that 143 PBSPs had been submitted for review and approval between 1/1/2013 and 6/20/2013 (36 days prior to the end of the current site visit). For these 143 PBSPs, there were indications of frequent delays in approval and implementation. Of the 143 PBSPs reviewed, only 183 (84%) had been implemented by the end of the current site visit. • An average of 9.1 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 91 days. • An average of 5.1 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 23 days. • An average of 29.8 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 104 days. • An average of 10.8 days was documented between final approval of a PBSP and the implementation of the PBSP. The number of days documented between final approval by the Human Rights Committee and implementation of the PBSP ranged from zero days to 90 days. Twenty of 94 (21%) PBSPs were implemented more than 14 days after final approval. Based upon the information presented above, it was evident that DSSLC had substantially	Noncompliance

#	Provision	Assessment of Status	Compliance
		improved upon the ability to provide timely behavior intervention for many individuals determined to be in need of a PBSP. PBSP Review Historical Perspective 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 observational functional assessments. Beginning in late 2010 and continuing into early 2012, DSSLC had engaged in continual overhaul of the behavior assessment and intervention process. The result was that the number of completed PBSPs available for review was relatively small. 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. In October 2012, 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. Limitations were noted only concerning strategies for teaching replacement behaviors and descriptions of data collection methods. Current Site Visit At the time of the current site visit, a sample of 10 records was selected for review using the process previously described. The table below reflects a review of those 10 records.	

PBSP Element	Baseline	10/2012	7/2013
Rationale for selection of the proposed intervention	50%	89%	100%
History of prior intervention strategies and outcomes	50%	100%	100%
Consideration of medical, psychiatric and healthcare issues	40%	94%	100%
Operational definitions of target behaviors	70%	89%	100%
Operational definitions of replacement behaviors	70%	83%	100%
Description of potential function(s) of behavior	30%	83%	100%
Use of positive reinforcement sufficient for	10%	83%	100%

#	Provision	Assessment of Status	Compliance

strengthening desired behavior			
Strategies addressing setting event and motivating operation issues	60%	83%	100%
Strategies addressing antecedent issues	60%	83%	100%
Strategies that include the teaching of desired replacement behaviors	10%	72%	50%
Strategies to weaken undesired behavior	30%	100%	100%
Description of data collection procedures	20%	67%	100%
Baseline or comparison data	0%	100%	100%
Treatment expectations and timeframes written in objective, observable, and measureable terms	0%	94%	100%
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%
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 continued to provide sophisticated and evidence-based behavior intervention plans. In the majority of areas, including descriptions of data collection procedures, the PBSPs developed by DSSLC easily met accepted practices in the field of applied behavior analysis.

In only one area were substantial limitations revealed in the PBSPs.

Strategies for Teaching Replacement Behaviors

In five of 10 reviewed PBSPs (50%), the plan did not include a structured approach to teaching a replacement behavior identified in the functional assessment. All of the plans lacking a teaching methodology included a section for presenting teaching strategies, and in some plans, this section included detailed instructions. These instructions consisted primarily of steps that addressed antecedent issues and would help to avoid displays of the target behavior. Although these steps might be beneficial, they did not reflect a methodology likely to strengthen functionally equivalent replacement behaviors.

- For Individual #68, the teaching section of the PBSP included only three general instructions for encouraging the individual to wear a weighted vest. Assessments had supported the use of the vest and trial uses of the vest had resulted in substantially lower rates of undesired behavior, all of which

#	Provision	Assessment of Status	Compliance
		suggested that the use of the vest was likely to be beneficial. Nevertheless, this component of the PBSP did not constitute the teaching of a replacement behavior, but rather reflected a novel approach to altering the antecedent conditions for the behavior, accompanied by supporting assessments and data to indicate level of effectiveness. • The PBSP for Individual # 781 contained the following steps in the section for describing teaching strategies. o This individual can and will do things to get your attention. She will not do these things as much if she is able to talk to you about what is bothering her. The reason for this section is to get this individual to talk with you. o If this individual is upset (pacing or yelling) or if she is refusing to do things, you should go up to her and ask her "what is wrong? How can I help you?" o Your job is to listen to her. This means that you talk as little as possible and if you do talk to her you say things like, "I hear you", or "I can understand why you feel that way." o You should not say things like, "I do not believe you", or "You should not feel that way", or, "Get over it this individual, it is not that bad." o If this individual does not want to talk then let her know that you are here to listen and remain nearby. Ask her every 30 minutes how she is doing and if she wants to talk. Keep doing this until she no longer appears anxious. o If this individual talks with you about what is bothering her without hitting or making a suicide gesture, then mark an instance of "talks with staff" on the behavior data sheet. Although these steps could prove to be helpful, they did not reflect a systematic approach to teaching a functionally equivalent behavior. A more appropriate methodology might have included providing reinforcement in the form of attention when the individual verbally or physically indicated the need to talk with staff. Based upon the review of 10 recent PBSPs, it did appear that considerable improvement had been achieved in the majority of components of the PBSPs. In addition, the Facility had substantially reduced the delay in implementing most PBSPs. In order to obtain substantial compliance, however, the Facility will need to ensure that PBSPs address identified functions by implementing programs and strategies to teach or strengthen replacement behaviors. This program must provide structured, evidence-based strategies for skill acquisition and behavior change.	
K10	Commencing within six months of	<u>Historical Perspective</u>	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td>During the 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.

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.

In October 2012, a review of 18 records revealed that some improvement had been achieved. At the same time, however, some areas, such as condition change lines, had regressed.

<u>Current Site Visit</u>
At the time of the current site visit, a sample of 24 records was selected for review using the process previously described. The table below reflects a review of those 24 records.

<table>
<tr><th>Graph Element</th><th>Baseline</th><th>10/2012</th><th>7/2013</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>100%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>100%</td><td>88%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>67%</td><td>100%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>67%</td><td>100%</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>67%</td><td>100%</td></tr>
</table>

Based upon the review of the PBSPs and data graphs, it did appear that improvement had been achieved and maintained in many areas. Three graphs lacked a title for the secondary vertical axis. The greatest weakness, however, was the lack of IOA or treatment integrity data on the graphs.

Although DSSLC reported that improvements were ongoing in collecting and reporting inter-observer agreement, this was not evident in the documentation submitted by the Facility. For some individuals, problems encountered in staff completion of data</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		collection were mentioned in the narrative of progress notes. On several progress notes, the percentage 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.	
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. A review of 10 records revealed that that the readability requirement was enforced by the peer review process.	Substantial Compliance
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.	During the site visit, it was noted that the competency-based training for DSP staff provided by the Behavior Analysis Research Clinic (BARC) staff from the University of North Texas had continued. In addition, the training had expanded to include Behavior Services staff. 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. For the first element of the training, DSP staff were required to participate in three vignettes and demonstrate how to address the behaviors modeled by the BARC trainers in those vignettes. The DSP staff were then presented live and video-based training on skills appropriate for each vignette. The DSP staff were then presented on the following day with the same vignettes and were scored on their responses. 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 DSP staff were then tasked with collecting data and answering questions related to data collection. 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 DSP staff were then required to demonstrate competence for each PBSP. Training data provided by BARC reflected that all staff consistently improved skills related to all three elements of the training.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Only a limited number of DSPs could be included in BARC training. In order to gain some insight into the familiarity of DSP staff with PBSPs they were responsible for implementing, 14 staff were interviewed about PBSPs for which they were responsible. • Five of 14 staff (36%) demonstrated working knowledge of the implementation instructions of at least one PBSP without having to access the plan. • Four of 14 staff (29%) could describe data collection procedures for at least one PBSP without having to access the plan. • Three of 14 staff (21%) indicated that they were familiar with all materials necessary to implement at least one PBSP. Based upon observations, interviews, and record reviews, substantial limitations were noted in the ability of the Facility to ensure that all direct contact staff and their supervisors were competent concerning the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	
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 eleven staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 44 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 employed sufficient Psychology Assistants to provide one Psychology Assistant for every two full-time psychologists.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/2013 2. DSSLC Action Plan 6/21/2013 3. DSSLC Presentation Book, Section L (undated) 4. DADS Policy: 009.2 Medical Care, dated 5/15/2013 5. DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number 6. DSSLC Policy Medical 01 – Medical Care Exhibit G: Process for Consultations, dated July 1, 2013 7. DSSLC Policy Infection Prevention and Control, dated 3/15/2013 (not numbered) 8. DSSLC Policy Med-01 Medical Quality Assurance Exhibit H, dated July 1, 2013 9. DSSLC Clinical Death Review Policies and Procedure Manual, Committees and Councils – 07A, Date: May 15, 2006 10. DSSLC Administrative Death Review Committee, Policies and Procedure Manual, Committees and Councils – 07B, Date: May 1, 2006 11. DSSLC Final Comprehensive Nursing Assessment for Individuals #3, #80, #460, and #740 12. DSSLC Death/Discharge Summaries for Individuals #3, #80, #460, and #740 13. DSSLC Clinical and Administrative Death Review Tracking Log for Individuals #3, #80, #460, and #740 14. DSSLC Clinical and Administrative Death Review Recommendation Tracking Logs for Individuals #3, #80, #460, and #740 15. DSSLC Unusual Incident Investigation Reports for Deaths for Individuals #3, #80, #460, and #740 16. Texas Department of State Health Services – Vital Statistics Unit, Death Certificates for Individuals #3, #80, #460, and #740 17. DSSLC List of Deaths including Individuals #3, #80, #460, #740, #443, and #462 18. DSSLC Analysis of Death summarizing deaths from June 2009 through May 2013.\ 19. Action plan related to clinical indicators, October 2012 – June 2013 20. DSSL QA/QI Council Meeting Data Analysis Report for January 2013 through June 2013 21. Internal Health Service Compliance Audits for January 2013 through June 2013 22. Guideline for DSP, Osteoporosis Guidelines For the DSP (undated) 23. Medical audit results, data sheets, analysis, summaries, action plans, and follow-up on action plans for the external and internal physician audits 24. For Individuals #365, #575, #576, #117, and #220: a. Most recent medical assessment b. Most recent quarterly medical assessment c. Individual Support Plan (ISP) documented rationale for Do Not Resuscitate (DNR) d. Copy of ethics review for DNR e. Copy of consent for DRN f. Copy of specific DNR form g. Copy of the medical prescriber's IPN documenting the clinical rationale for the DNR h. Copy of specific instruction for staff documenting the specific type of DNR 25. For Individuals #11, #430, #602, #129 (x2) and #207: a. Hospital admission and discharge summary

	b. Copy of medical provider's Doc-to-Doc communication c. Nurse liaison follow-up at hospital d. Post hospital Nursing Follow-up e. Post hospital IPN by the medical provider, through full resolution of the discharge condition 26. For Individuals #656, #170, #595, #42, and #394 a. Most recent annual medical assessment b. Most recent two quarterly medical assessments c. Seizure record, and cumulative seizure records d. Most recent two neurology consultations e. Any hospital/ER discharge notes, specific to an admission for seizure related condition f. Most recent brain imaging, and EEG reports g. All IDT minutes specific to the management, and follow-up on seizure disorder 27. For Individuals #285, #37, #205, #461, and #492: a. Most recent medical assessment b. Most recent PT/OT assessment specific for the fracture c. All medical provider's IPNs, specific to assessment and follow-up through resolution of the fracture d. Most recent updated Integrated Risk Rating Form (IRRF) e. ISP or addendum to the ISP, specific for the fracture f. Most recent bone density study g. Current medication list h. Labs for past 12 months 28. For Individuals #170, #595, #42, #656, and 394 a. Most recent annual medical assessment b. Most recent two quarterly medical assessments c. Seizure record, and cumulative seizure records d. Most recent two neurology consultations e. Any hospital/ER discharge notes, specific to an admission for seizure related condition f. Most recent brain imaging, and EEG reports g. All IDT minutes specific to the management, and follow-up on seizure disorder 29. For Individuals #285, #37, #205, #461, and #492: a. Most recent medical assessment b. Most recent PT/OT assessment specific for the fracture c. All medical provider's IPNs, specific to assessment and follow-up through resolution of the fracture d. Most recent updated IRRF e. ISP or addendum to the ISP, specific for the fracture f. Most recent bone density study g. Current medication list h. Labs for past 12 months 30. For Individuals #279, #345, #398, #235, and #417 a. Annual medical assessment

	b. Imaging studies used to evaluate the spine c. All consultations specific to evaluation of the spine d. ISP and IRRF e. Most recent PT/OT assessment, and all treatment notes for spine disease 31. Document entitled "Physical Nutritional Management Committee, Clinical Indicators Actions and Results, October 2012 – June 2013" 32. List of all individuals who have had more then three cases of pneumonia, during the past five years 33. For Individuals #326, #42, #129, #305, #551, #20, #739, #690, #466, and #664: a. Most recent annual medical summary b. Most recent IRRF c. Most Recent PT-OT assessment d. Current medication list e. Medical consultations, that specifically evaluate the individual to help mitigate recurrent pneumonia f. Most recent PNMT minutes g. Aspiration Risk Reduction Interdisciplinary Protocol (undated) 34. For Individuals #11, #650, #474, #279. #445, #292, #509, #715, #158, and #335 a. Most recent annual medical assessment b. Most recent medication list c. Most recent two bone density studies d. Most recent labs for the past 12 months e. Most recent IRRF f. Documentation that the medical provider has either documented the cause of low bone density, or had conducted an evaluation to exclude reversible causes, such as hypogonadism 35. For Individuals #170, #367, #474, #580, #416, #335, #581, and #52: a. Client Immunizations Master Report (immunization record) b. Complete immunization record, including documentation of childhood, and adult vaccination c. Clinical rationale why immunization was not current with CDC recommendation immunization 36. List of all individuals 50 years and older, and indication if screening colonoscopy was current, and if not, why not 37. List of all female individuals 40 years and older, and indication if screening mammogram was current, and if not, why not 38. List of all medical providers, and support staff 39. Copy of current CPR certificate, and Texas license to practice medicine 40. List of all continuing medical education (CME) attended by the medical provider, during the reporting period. 41. List of all support staff for medical services 42. Copy of the Protocol for the Integrated Morning Report 43. Copy of the Integrated Morning Report Meeting Log, from 3/4/2013 to 3/8/2013 44. List of all fractures during the past six months 45. List of all individuals diagnosed with osteoporosis 46. List of all individuals who experienced three or more episodes on pneumonia in the past five years

	47. List of all individuals who experienced an episode of status epilepticus during the past six months 48. List of all individuals with active DNR orders **People Interviewed:** 1. Dr. Stephen Kubala, MD Medical Director **Meeting Attended/Observations:** 1. Integrated Morning Report meeting 2. Observations rounds at: a. Cedar Falls 502 b. Infirmary c. Timberhill 509, 511, 510 d. Houston Park 3. Mortality Review Meeting: a. Delia Schilder, RN, Chief Nurse Executive (CNE) b. Sherri Courtney, RN, Nursing Operations Officer (NOO) c. Laura Stoffels, RN, Nurse Investigator d. Stephen Kubala, MD, Medical Director e. Diane Tompkins, Health Services Compliance Officer
	Facility Self-Assessment: Review of the Facility's self-assessment indicated that the Facility is completing a more data driven assessment process, and has identified many appropriate items for the assessment, and concurred with the Facility's determination of noncompliance for Provision L.1. The Facility is using an assessment tool that is outcome oriented, and based on specific data elements. The Monitoring Team concurred with many of the self-assessment findings; for example, the Monitoring Team concurs with the Facility's determination of accuracy of determining that the problem list documented ICD-9 diagnosis. The Monitoring Team noted, however, that the Facility did not have a process to determine if the quality of issues being monitored was clinically appropriate, and were clinical actions based on a rational, acceptable standard of care. For example: The self-assessment documented that a physician participated at 44% of the ISP meetings, and while this maybe true, the assessment did not determine if the physician provided meaningful substance to the ISP meeting. The self-assessment determined that 93% of samples assessing the management of seizures was "proper", and based its determination on the internal medical management audit for seizures; the internal medical audit did not assess many important clinical management issues related to seizure disorder. The self-assessment indicated that 100% of all DNRs were determined to be "rational"; however, the Monitoring Team noted significant deficiencies with the DNR review process. For Provision L.2, the Monitoring Team disagrees with the Facility's self-assessment of substantial compliance. Although the self-assessment focused on specific and data driven elements, the Facility again did not consider the quality of action being assessed; for example the Facility indicated that after reviewing four of four mortality reviews, all four were completed within the required timeframe, and recommendations had been tracked for completion. While both of these statements are absolutely true, the Monitoring Team noted that the mortality review did not fully explore the potential contributing factors of the death, and that recommendations needed to be enhanced.

	The self-assessment for both Provisions L.3, and L.4 indicated noncompliance, and the Monitoring Team concurred with that assessment. For Provision L3, the Facility should look closely at the recommendations provided in this report, and should ensure self-assessment addresses those for the next visit. The Monitoring Team reviewed the action plan for Provision L, and recommends the Facility to develop action steps, specific for assessing outcome assessments, based on the quality of the content of items being assessed.
	Summary of Monitor's Assessment: The following are the Monitoring Team's comments and concerns for Section L of the Settlement Agreement: Provision L.1: The Monitoring Team recognizes the diligent work by the Facility to enhance medical care to individuals who reside at the Facility. The medical department continues to improve in many areas. The Monitoring Team is especially complimentary for the improved, and much more comprehensive annual medical assessments; the comprehensiveness of the PNMT process; and enhanced efforts for follow-up on pneumonia, decubitus ulcers, and serious injuries. The Monitoring Team also recognizes that follow up to many medical issues, was much more comprehensive, and efficacious, than in the past. Documentation practice has also significantly improved with regards to IPNs being written in the SOAP format, and enhanced documentation of action plans being provided for each diagnosed condition. Compliance will require further improvements by enhancing clinical management of various medical conditions, including pneumonia, fractures, and seizures. The Facility must also review its process to ensure that indications for DNRs are clinically justifiable, and that the ethics committee and IDT assertively evaluate the necessity of a DNR, prior to initiating a DNR, and at least annually thereafter. Provision L.2: The Facility conducts regularly scheduled internal and external medical audits, to help assess the clinical performance of physicians. Action plans were developed, implemented, and completed. The Facility must enhance the medical audit process by ensuring that medical management elements are developed for the most common and most serious medical conditions that occur in people with intellectual disability; that a sound sample of records are reviewed for each audit; and that the results of the audits are used by the Facility to help enhance and monitor physician performance. In addition to process, the audits should assess the quality of items being audited. The Monitoring Team was pleased to learn that the medical director utilized the medical audit process as a component of peer review, and that he discussed the results with each clinical provider. The Monitoring Team's review of the Facility's mortality review process noted improvement since the last review; however, the Facility must enhance its process further, in order to ensure that meaningful recommendations occur and lead to systems improvements. Also, the clinical review must better assess all contributing factors that may have played a role in the death. For example, when following up on an pneumonia related death, the committee should determine if the medical provider assessed the efficacy of supports, such as ensuring that positioning, tube feeding, transfers, and other physical and mechanical

	support are done safely and effectively. Provision L.3: The Facility has made substantial progress toward development of an effective medical quality assurance system. The Facility developed, and implemented a data-driven process to track, and trend medical outcome indicators, for the purpose of enhancing clinical care at the Facility. Outcome indicators were well considered, and include topics such as pneumonia, other respirator infections, fractures, and other injures, and management of diabetes, among many others. Data is maintained by a functional electronic database system, and regularly analyzed for trends. Data and trends analysis were reviewed as a component of the Facility's robust QA/QI program, and along with recommendations for process improvements, were incorporated into a comprehensive QA/QI report. There was evidence to support that the medical director utilizes the QA/QI report to develop processes to enhance clinical outcome. However, the Facility did not demonstrate that the process is yet structured and formalized enough so that issues needing to be addressed will routinely be evident and actions documented. Provision L.4: The Monitoring Team reviewed, and concurred with, the Facility's new policies for medical consultations and medical QA/QI, and is compliments the State Office for developing a robust policy to address many medical issues, as delineated by its new medical policy. Compliance will require that the policy become substantially implemented at the Facility. The Monitoring Team recommends that DADS develop clinical pathways that are ID/DD specific, for the most common and significant medical conditions that occur within the context of a DD Facility.

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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.	To assess compliance with Provision L.1 of the Settlement Agreement, the Monitoring Team observed individuals at their homes and day programs, attended the Integrated Morning Report (IMR) meeting, and discussed compliance issues with the medical director. Provision L.1 is most comprehensive, and for this review period the Monitoring Team assessed the following topics: • Medical Administration • Seizure Disorder • Preventive health issues: immunization, colon cancer screening, and breast cancer screening • Follow-up to acute hospitalizations • Myelopathy, and degenerative spine disease • Recurrent pneumonia • Fractures • DNR **Medical Administration** To assess medical administration, the Monitoring Team reviewed: • List of all medical providers, and support staff	Noncompliance

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		• Copy of current CPR, and Texas license to practice medicine • List of all CME attended by the medical provider, during the reporting period • List of all support staff for medical services • Copy of the Protocol for the Integrated Morning Report • Copy of the Morning Meeting Log, from 3/4/2013 to 3/8/2013 In addition, the Monitoring Team attending the IMR, and reviewed the Facility's procedure: Integrated Morning Report. The Facility maintained the following professional medical staff, and support staff: • Six full-time medical doctors to provide direct care • One part-time medical doctor to provide direct care • One full-time medical director • Two full-time nurse practitioners • One full-time administrative assistant • Three full-time nurses to support the medical clinic Ten out of ten (100%) medical providers were currently licensed in Texas, and nine of the 10 (90%) were current with CPR training. One of the medical providers was granted a reasonable accommodation to be exempted from CPR training. All medical providers participated in official continuing medical education, and were current with required CME training. Discussion with medical director: While discussing compliance issues with the medical director, the Monitoring Team was informed of the Facility's enhanced PNMT process, and robust processes to follow-up on pneumonia, and decubitus ulcers. Documentation: The Monitoring Team review found annual medical assessment and IPNs had significantly improved. All IPNs were in SOAP format, and all annuals had appropriate ICD-9 diagnosis, and there were corresponding medical actions plans listed for most diagnoses on the annual medical assessment (although only one medical assessment reviewed had an action plan for every diagnosis). The Monitoring Team did have concern over the content of the information documented, and examples of these concerns are delineated below, under specific medical conditions. Observation of the Integrated Morning Report: The Monitoring Team observation of the IMR indicated a robust process whereby clinical issues that occurred during the preceding night, current hospital admissions, and significant clinical events, were discussed through a multidisciplinary approach, that included a pharmacist, medical director, unit medical providers, unit and clinic nurses, physical and occupational therapist, psychologist, psychiatrist, and QDDP coordinator.	

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		The meeting was conducted efficiently and efficaciously. Review of the Morning Meeting Log form, for the week of March 4, 2013, indicated that the PCP on-Call Log report, was not fully completed, as there was no documentation for the sections: referrals, follow-up, and closure. The Facility maintains a robust, qualified, professional medical staff, and support staff. The IMR meeting was determined to be efficacious, however, documentation of meeting events should be improved. **Screening Mammogram** The Monitoring Team reviewed a list of all females, age 40 years and older; a Facility list of all individuals who were not current with their annual mammogram, and documented clinical rationale for individuals not current with annual mammogram screening. • There were 197 female individuals, age 40 and older: • One hundred eighty six of 197 individuals (94%) were reported current with their annual screening mammography • Of the 11 out of 197 (6%) individuals who were not current: o Eight out of 11 (73%) had well documented clinical rationale for not completing a mammogram breast cancer screen. o Three out of 11 (3%) were delinquent because the medical provider did not provide a request for a mammogram. The Monitoring Team is complimentary to the Facility for its assertive breast cancer screen program, but recommends that Facility ensure that there is documented evidence for not completing an annual mammography for all females age 40 and greater. **Screening Colonoscopy** The Monitoring Team reviewed a list of all individuals, age 50 years and older; a Facility list of all individuals who were not current with a colonoscopy for colon cancer screening, and documented clinical rationale for individuals not current a screening colonoscopy. • There were 304 individuals, age 50 and older: • Two hundred ninety seven out of 304 (98%) individuals were reported current with screening colonoscopy • Of the seven out of 297 (2%) individuals who were not current: o One out of seven (14%) had not been scheduled. o Four out of seven (57%) were not completed because of refusal by the LAR. o Two out of seven (29%) were not completed because of challenging behavior issue.	

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		The Monitoring Team is complimentary to the Facility for its robust colon cancer screening process. **Immunization / Vaccination** In addition to the Facility's policy for immunization, the Monitoring Team requested immunization records the first, and then every fifth individual, for a total of ten samples, from a list of individuals who resided at the Facility (Individuals #170, #367, #474, #508, #580, #416, #335, #581, #697, #52), and reviewed: • Client Immunizations Master Report (immunization record) • Complete immunization record, including documentation of childhood, and adult vaccination • Clinical rationale why immunization was not current with CDC recommendation immunization The Facility provided the Monitoring Team with a copy of the DSSLC Policy Infection Prevention and Control, dated 3/15/2013 (not numbered). The policy was specific for employee health services, and did not address immunization and vaccination of individuals. Of the ten samples requested, the Monitoring Team was presented with eight (#170, #367, #474, #580, #416, #335, #581, #52): • Three out of eight (34%) examples were either vaccinated, or demonstrated serological markers to prove immunization for Measles, Mumps, and Rubella • Six out of eight (75%) examples were current with either TD, or TDap. • Four out of eight (50%) examples were either vaccinated, or demonstrated serological markers to prove immunization for Polio. • Eight out of eight (100%) examples were provided influenza vaccination for 2012. • Six out of eight (75%) examples were either vaccinated, or demonstrated serological markers to prove immunization for Varicella Zoster. • Two out of eight (25%) examples were either vaccinated, or demonstrated serological markers to prove immunization for Herpes Zoster. • Six out of eight (75%) examples were either vaccinated, or demonstrated serological markers to prove immunization for Hepatitis B. Because a policy for vaccination and immunization was not provided, the Monitoring Team was unable to determine if the Facility's policy reflected CDC recommendations for immunization and vaccination. The Monitoring Team is concerned over the low rate of individuals who were current with CDC recommended immunizations.	

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		Osteoporosis To Assess the Facility's management of osteoporosis, the Monitoring Team request all related policies, a list of all individuals diagnosed with osteoporosis, and for the first ten individuals on the list, a copy of: • Most recent annual medical assessment • Most recent medication list • Most recent two bone density studies • Most recent labs for the past 12 months • Most recent IRRF • Documentation that the medical provider has either documented the cause of low bone density, or had conducted an evaluation to exclude reversible causes, such as hypogonadism Review of the Facility's "Osteoporosis Guidelines for the PCP" (undated) indicated an excellent general review of osteoporosis; however, there was no information specific to how osteoporosis may affect individuals with developmental disabilities, and no comment on management issues or treatment risks/benefits of low bone density for younger adults. The Facility developed guidelines for Direct Support Professionals (DSPs), Osteoporosis Guidelines For the DSP (undated). The Monitoring Team was not made aware of how these guidelines were disseminated. Review of the requested documents for Individuals #11, #650, #474, #279. #445, #292, #509, #715, #158, and #335 found: • Ten out of ten samples (100%), indicated the diagnosis of either osteoporosis or osteopenia. • Ten out of ten annual medical summaries (100%) indicated a medical plan, specific for osteoporosis or osteopenia. The Monitoring Team would like to point out that some plans were much better than others. For example, the plans for Individuals #715, #335, and #158 were limited (Individual #158 stated "Continue with Calcium + Vitamin D. Continue Fosamax 70mg per week. Repeat DEXA scan is due"); while the plan for Individual #445 was more comprehensive, and included details about monitoring parameters. • Nine of ten samples (90%) indicated that individuals were provided vitamin D, Calcium and a bisphosphonate, or other treatment, when clinically indicated. o Individual #158, was not prescribed vitamin D, per review of the medication list • Ten out of ten samples (100%) were assessed for low bone density, when clinically	

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		appropriate. o Individual #158 did not have a current DEXA scan; however, there was well documented clinical rationale for the reason that the study was not obtained. • Zero out of ten samples (0%) demonstrated documented evidence that the medical provider fully assessed the individual for potential secondary causes of low bone density. It is obligatory to ensure secondary causes of osteoporosis are evaluated, especially prior to treatment of males and younger adults. • Nine out of ten samples (90%) included an assessment of risk for osteoporosis on the IRRF. The IRRF for #158 was not provided for review. The Monitoring Team noted that some risk assessments did not fully consider risks associated with osteoporosis. For example: o The IRRF for Individual #445 indicated only a medium risk for osteoporosis, despite the individual on maximum medical therapy. Also, the risk rating for fracture was determined to be low, despite osteoporosis in the past, current diagnosis of osteopenia, and noted to be at risk for falls. o The IRRF for Individual #715 had an appropriate assessment for osteoporosis; however, despite the diagnosis of osteoporosis, and the use of a mechanical lift, bed rails, and physical supports for transfers, the IRRF assessment for fracture was only a medium. o The IRRF assessment for Individual #335 indicated a high risk for osteoporosis, and provided good insight into fractures, secondary to the risk of osteoporosis. In general, the Facility has made significant improvement with the diagnosis, monitoring and treatment of low bone density. Although the Facility has also made improvements with the IRRF process, further improvements are necessary, especially for the assessment for osteoporosis and related conditions. The underlying etiology, or evidence that there was a search for secondary cause of osteoporosis must be documented. **Recurrent Pneumonia** To assess the Facility's management of recurrent pneumonia, the Monitoring Team reviewed: • Document entitled "Physical Nutritional Management Committee, Clinical Indicators Actions and Results, October 2012 – June 2013" • List of all individuals who have had more then three cases of pneumonia during the past five years • For individuals #326, #42, #129, #305, #551, #20, #739, #690, #466, #664: o Most recent annual medical summary	

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		o Most recent IRRF o Most Recent PT-OT assessment o Current medication list o Medical consultations, that specifically evaluate the individual to help mitigate recurrent pneumonia o Most recent PNMT minutes • Aspiration Risk Reduction Interdisciplinary Protocol (undated) • Document entitled "Pneumonia Additional Discussion", dated 6/27/2013 • Document entitled "Reducing The Risks For Aspiration Pneumonia For the PCP" (undated) • Document entitled "Work Sheet" (undated) The Monitoring Team reviewed the following documents that were provided by the Facility: • The "Pneumonia Additional Discussion" document, dated 6/27/2013, provided a robust review of important clinical issues related to the reduction of pneumonia. However, despite over fifteen valid comments and recommendations, there was no comment about the need to more closely monitor the positioning of individuals, support with feeding, issues related to physical and mechanical transferring of individuals, and earlier recognition of subtle signs of pneumonia. The Monitoring Team, as referenced in Provision O.4, of this report, had identified significant concern with positioning, and with assistance with meals. • Review of the document entitled "Reducing The Risks For Aspiration Pneumonia For the PCP" (undated), the Monitoring Team noted excellent pointers that could help prevent aspiration pneumonia; however, there was no recommendation for the PCP to periodically assess the position of the individual (while in his/her wheelchair, and bed), and how individuals were being supported during meal time. The Monitoring Team highly recommends that the medical providers assess the functionality of positioning, and feeding-related support, including physical supports and tube feeding schedules. • The document entitled "Work Sheet" (undated), including a comment about positioning issues, and questioned the medical provider to consider the following: if a physical therapy consult had been done; was the head of the bed up at an angle as recommended by the HOBE; and when was the individual's positioning needs evaluated last. The Monitoring Team strongly recommends that medical providers actually observe the individual at his/her home and work place, to ensure that positioning and other critical supports, including physical supports for meals, and tube feeding schedules, are provided as prescribed, and are functionally meeting the needs of the individual. • The document entitled "Aspiration Risk Reduction Interdisciplinary Protocol", dated	

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		10/5/11, provided excellent recommendations to help mitigate aspiration; however, the associated flow-diagram, and the list of aspiration risks factors, did not take the following issues into account: positioning of the individuals (while in bed and wheelchair); use of mechanical or physical lifts, and support during meals, including physical supports, and tube feeding schedules. • Review of the bar graph data, as depicted on the documented entitled "PNMC Clinical Indicators Actions and Results, for October 2012 through June 2013", indicated a marked increase in the incidence of pneumonia for the past six months, as compared to the same six-month period in 2012 (raw numbers for the incidence of pneumonia during this time frame, were not provided for review). The associated action plan documented excellent recommendations to help minimize the incidence of pneumonia; however, there were no recommendations to better assess positioning issues, physical and mechanical transferring of the individual, and supports to assist with meals, including physical supports, and tube feeding schedules. The Facility provided a list of all individuals who experienced three or more incidences of pneumonia during the past five-year period. There were 39 unique individuals on the list; 14 of the individuals had ten or more incidences of pneumonia reported during that time frame. For Individuals #326, #42, #129, #305, #551, #20, #739, #690, #466, and #664: • Six out of ten annual medical assessments (60%) listed a diagnosis of recurrent pneumonia on the associated active problem list. o Individuals #664, #466, #739, and #326 did not indicated recurrent pneumonia or history of recurrent pneumonia on the action plan component of the annual medical assessment • Five out of ten action plans (50%), as listed on the annual medical assessment, documented a clinically rational action plan for recurrent pneumonia. For example: o The action plan for Individuals #466 and #690 documented a comprehensive action plan that discussed, in addition to medical management, specific positioning issues, and in the case of Individual #690, what to observe for. o The action plan for Individual #129 merely stated "H/O Asthma and recurrent pneumonia in the past. Since the admission of 11/2011, the patient has been stable with pulmonary status". There was no discussion about risk issues and positioning issues. It should be noted that the individual was hospitalized for a significant case of pneumonia in May 2013, and there was no medical provider IPN documenting an update for the management to help minimize the recurrence of pneumonia. • There was indication that a specialist was consulted, specifically to help identify	

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		factors, and strategies to help minimize recurrent pneumonia, in two of ten examples (20%) o The Monitoring Team noted a consult report dated 6/5/2013, that documented an excellent overview of the history of pneumonia, and potential for developing additional pneumonia in the future. There was no comment regarding possible procedures to help reduce aspiration pneumonia, such as fundoplication, and tracheal diversions; and there was no comment on issues related to positioning. • The Monitoring Team reviewed associated integrated risk rating forms (IRRFs), and all indicated some risks for either pulmonary issues, and/or aspiration risks; however, in general, the risk ratings did not provide an adequate reflection of the serious risks associated with aspiration pneumonia. For example: o The most recent IRRF for Individual #664 indicated a medium risk for respiratory compromise, and that there had been no pneumonia since 6/2012. The risk factor for aspiration was also rated medium and stated "had no aspiration pneumonia in the past year, and the team agreed that the current plan was working well to prevent aspiration pneumonia". This individual had five episodes of aspiration pneumonia in the past five years, has a diagnosis of pharyngeal dysphasia, and history of rumination of food and more then five episodes of aspiration pneumonia in the past. o Individual #466 had experienced 12 episodes of pneumonia during the past five years, with the most recent episode occurring in March 2013. Although the risk rating for respiratory compromise was high, the facility did not comment on the specific risk factors for recurrent aspiration pneumonia. When discussing the current status for respiratory compromise, the Facility responded by stating: "supports appear to be somewhat effective as evidence by several diagnosis of respiratory compromise documented this year", and for proposed recommendations, the IDT indicated "no new recommendations made before the ISP". With a history of 12 incidences of pneumonia in the past five years, three of them occurring during the previous year, and one as recent as two months before development of the IRRF, the Monitoring Team has serious concerns over the Facility's ability to identify, and develop meaningful action plans for, risks of serious clinical conditions. The Monitoring Team recognized the extraordinary efforts made by the Facility to help reduce the incidences of pneumonia, and realizes that in some cases, the incidence may not be able to be eliminated. However, issues such as potential medical treatments, such as tracheal diversion, and fundoplication; effective monitoring of supports, such as assistance with meals, transfers, positioning, and tube feeding schedules; and early recognition of signs of pneumonia, must all be well incorporated into the assessment and	

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		plan for each individual with pneumonia associated risks. **Myelopathy/Degenerative Spine Disease** To assess the Facility's management of myelopathy, the Monitoring Team requested a list of all individuals with a diagnosis of myelopathy, and from that list for the first, and every fifth individual after the first, a copy of: • Annual medical assessment • Imaging studies used to evaluate the spine • All consultations specific to evaluation of the spine • ISP and IRRF • Most recent PT/OT assessment, and all treatment notes for spine disease A total of 30 individuals were identified by the Facility as having spondylosis. For Individuals #279, #345, #398, #235, and #417: • Five out of five annual medical summaries (100%) indicated a diagnosis of spine disease. • Zero out of five annual medical summaries (0%) indicated a clinically rational action plan, that documented the significance and severity of spondylosis, specific details on how this condition could impact the individual, and specific monitoring parameters, to evaluate for progression of the disease. • Zero out of five annual medical summaries (0%) documented a physical assessment to accurately quantitate range of motion, muscle tone, and when possible, sensorium. • Zero out of five annual medical summaries (0%) documented specifics on how to assess and provide ongoing monitoring for pain. • Zero out of five IRRFs (0%) documented specifics on how to assess and provide ongoing monitoring for pain. • Zero out of five IRRFs (0%) indicated risks associated with spondylosis. • Zero out of five (0%) physical therapy and occupational therapy (PT/OT) assessment documented specific monitoring parameters, such as range of motion, and quantitating reflexes, to adequately assess progression of the disease. • For each of the five examples, there was no evidence of clinical follow-up with a spine specialist, to provide on-going monitoring for progression of the disease o Individual #235 has severe multilevel spondylosis, and a history of vertebral fracture. The most recent consultation with a spine specialist was June 2012, and at that time the consultant indicated to follow-up annually, as long as the individual remained stable. The annual medical assessment indicated that follow-up was "not required at this time". The annual medical assessment also documented the need for periodic x-ray of the spine to assess stability; however, the frequency of such evaluations was not documented.	

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		The Monitoring Team determined that the Facility's clinical management and monitoring of spondylosis, and related issues of spine disease, did not meet the needs of the individuals assessed. Given the Monitoring Team's observations of individuals at the living area, that indicated numerous individuals demonstrating signs of myelopathy, and the prevalence of spine disorders in this population, it is highly recommended that a formal process be developed to assess, and manage degenerative spine disease and myelopathy. **Fractures** To assess clinical management of fractures, the Monitoring Team request the following clinical information for the last five individuals from a list of all individuals who sustained a fracture during the reporting period (Individual #285, #37, #205, #461, #492): • Most recent medical assessment • Most recent PT/OT assessment specific for the fracture • All medical providers' IPNs, specific to assessment and follow-up through resolution of the fracture • Most recent updated IRRF • ISP or addendum to the ISP, specific for the fracture • Most recent bone density study • Current medication list • Labs for past 12 months Of the five samples reviewed by the Monitoring Team: • Four out of five (80%) examples indicated a diagnosis of either osteopenia, or osteoporosis, on the annual medical assessments active problem list o Individual #285 was treated for osteoporosis, and osteoporosis was listed in the IRRF; however, the condition was not listed on the annual medical assessment's active problem list, and there was no medical action plan developed for osteoporosis. • Five out of five (100%) examples included medical provider IPNs that documented the assessment and plan for the fracture, in SOAP format. • Five out of five (100%) examples included nursing IPNs that documented nursing follow-up of the fracture. • Five out of five (100%) examples included PT/OT assessments, specific for management of the fracture. • Four out of five (80%) examples include an IRRF rating for fracture risk as high • Zero out of five (0%) of the examples indicated a comprehensive assessment, by the medical provider, of the potential etiology for the fall, and fall risk.	

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		o All of the examples reviewed demonstrated evidence to indicate the individuals having significant musculoskeletal and/or neuromotor conditions. For example, Individual #285 was diagnosed with spastic quadriplegia, and bilateral hip dislocation; Individual #492 was diagnosed with arthritis, and had Alzheimer's Disease; and Individual #205 had worsening gait issues, and recent history of vertebral fractures. • Zero out of five (0%) examples indicated a review, by the medical provider, to assess the functionality of the PT-OT assessments, and if the recommended supports and services are meeting the individuals clinical needs. The medical provider is responsible for reviewing the PT-OT assessments and recommendation, and therefore is responsible for assessing efficacy and appropriateness. • The Monitoring Team had the following additional concerns o Individual #492 had 11 falls last year, and three falls during the first and second quarter of this year. It was also noted that the individual's gait had changed. There was no indication, by review of the annual medical assessment, IPNs, or quarterly medical assessments, that the individual's abnormal gait was evaluated. o Individual #205 was reported to have had 12 falls, and a known abnormal gait, but it was not until the last of three recent fractures, that the individual was assigned a gait belt. o Individual #205 was diagnosed with a recent fracture of the clavicle, nose, and compression fractures of the spine. In addition, the Individual was reported to have an abnormal gait. The Monitoring Team did not find evidence to support a comprehensive medical assessment for the abnormal gait, or evaluation for possible additional fractures. o Individual #461 had a several recent fractures, including fractures of the leg, ankle, and foot. The IRRF indicated that the Individual might be experiencing pain, and was provided Tylenol. Also reported by an addendum to the ISP was that the individual was experiencing self injurious behavior. Despite suspected pain, increase in self injurious behavior, high risk for falls and related injury, and recent fractures, there was no indication that a robust assessment for possible occult fractures, such as by assessing the individual with scout films, bone scan, or even a comprehensive physical examination. The Monitoring Team noted excellent triage and follow-up on fractures by the medical provider; however, the Monitoring Team is very concerned that medical providers were not assertive in evaluating the etiology of the fracture risk, and assessing the efficacy of supports and services to prevent falls and fracture. All individuals who demonstrate signs and symptoms of abnormal gait should be assessed as to the neuromotor and musculoskeletal etiology of the fracture risk, and the medical provider must carefully	

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		assess such conditions throughout the year. Positioning, and transfer issues must be periodically assessed for clinical efficacy. **Seizures** To assess the Facility's ability to manage seizure disorder, the Monitoring Team requested a list of all Individuals who experienced at least one episode of status epilepticus, during the reporting period, and for the first five individuals on the list: • Most recent annual medical assessment • Most recent two quarterly medical assessments • Seizure record, and cumulative seizure records • Most recent two neurology consultations • Any hospital/ER discharge notes, specific to an admission for seizure related condition • Most recent brain imaging, and EEG reports • All IDT minutes specific to the management, and follow-up on seizure disorder Following are findings for specific individuals: • Individual #170 • The annual, and most recent two quarterly medical assessment did not document how well the seizure disorder was controlled, comment or summarize on the frequency of seizures, or summarize the efficacy of treatment for seizure disorder, and there was no clinically rational target for seizure control. • There were a total of 12 seizures reported on seizure record forms; however, the cumulative seizure record had not been updated since February, and did not reflect the 12 seizures that had been reported. • Neurology consultation dated 2/27/2013, stated "sz's –last 12/11" "doing well". Hence the neurologist was not provided accurate data, which would have indicated that the individual had four reported seizures in January. • On 5/20/13, the individual had a seizure that lasted nine minutes, and no medication was provided to help mitigate the status epilepticus. • There was only one IPN documented by the medical provider for follow-up to a seizure, and that was on 4/10/2013. The note was in SOAP format, and documented a comprehensive assessment, impression and plan. There were no other IPNs provided, and it was apparent there the medical provider did not evaluate the Individual following the nine minute seizure on 5/30/2013. • Individual #595 • The annual, and most recent two quarterly medical assessment did not document how well the seizure disorder was controlled, comment or summarize on the frequency of seizures, or summarize the efficacy of treatment for seizure disorder,	

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		and there was no clinically rational target for seizure control. • The individual experienced 34 seizures since January 2, 2013. The seizure reports, and the cumulative seizure record were updated. • The Individual followed up with neurology on 4/18/2012, and was to been evaluated again by10/18/2012. The Individual was not evaluated until 3/13/2013, a full 11 months after the previous consult. • The most recent neurology consult report, dated 3/13/2013, indicated concern over continued seizure activity, and indicated that VNS may help reduce seizure. The Individual was to follow-up with the neurologist by 6/13/2013, but there was no subsequent neurology consultation report provided for review. • There were no IPNs documented by the medical provider, indicating evaluation following the numerous seizures experienced by the Individual. • There was no documentation by the IDT, of having discussed the numerous seizures, and the most recent neurology consultation that indicated a possible consideration for VNS. • Individual #42 • The most recent annual medical assessment, dated 1/15/2013, documented a very detailed summary of the individual's follow-up with neurology, and the action plan documented relevant clinical treatments; however, it did not document how well the seizure disorder was controlled, comment or summarize the frequency of seizures, or summarize the efficacy of treatment for seizure disorder, and there was no clinically rational target for seizure control. • Seizure records provided for review indicated a total of six seizures between 1/1/2013 and 3/16/2013. There were no seizure records provided for May or June 2013. The cumulative seizure record indicated a total of six seizures; however, the cumulative record indicated that two of the six occurred in June, and the Monitoring Team did not have seizure records for those two seizures. Also, the cumulative seizure record indicated only one seizure for March, while the Monitoring Team had three seizure records for March. • There was evidence that the medical provider evaluated the individual for a prolonged seizure on 6/27/2013. The IPN was comprehensive and in a SOAP format. • Individual #656 • The most recent annual medical assessment documented a very detailed summary of the Individual's follow-up with neurology, and the action plan documented relevant clinical treatments. There was a specific section called "Seizures", which documented the frequency of seizures over the past years. The medical action plan was exceptional, and clearly delineated the condition, and medical treatment plan.	

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		• The chronic problem note, dated 5/7/2013 documented a very good review of seizure disorder. • There was a Doc-to-Doc note that documented discussion with an acute care hospital physician on 6/10/2013, discussing the individual's recent seizure. • The cumulative seizure records indicated a total of 8 seizures since 1/1/2013, and that was consistent with the individual seizure record. • The individual had been seen by an epileptologist on 7/10/2013. Recommendations were made for a specific seizure record. The Monitoring Team did not find evidence to support that the medical provider had yet initiated the seizure record, as requested by the epileptologist. • Individual #394 • The annual, and most recent two quarterly medical assessment did not document how well the seizure disorder was controlled, comment or summarize on the frequency of seizures, or summarize the efficacy of treatment for seizure disorder, and there was no clinically rational target for seizure control. • The cumulative seizure record was completed through June, 2013, and indicated a total of 40 seizures. • There were no IPNs documented by the medical provider, following up to any of the 40 seizures reported during the past six months. Seizure disorder is a very common, serious, and potentially life threatening condition, for many individuals who have comorbid developmental disability. The management of seizure disorder must be assertive and multidisciplinary. The medical provider must be well aware of the frequency of seizures, possible precipitating factors, efficacy of treatment, and treatment goal. The IDT, through the ISP, must clearly document how seizure disorder impacts the individual's life, risks and benefits of treatments, treatment goal, and all necessary supports and services to aid the individual. In addition, the IDT should assess the risks and benefits of the use of older antiepileptic drugs, polypharmacy, when used, and evaluate the possibility of alternative treatments, such as VNS. In general, per the comments made for Individuals #170, #595, #42, and #394, the Monitoring Team did not see this level of attention. The clinical management of Individual #656 addressed the primary management of seizure disorder very well; however, better identifying treatment goals, and ensuring close follow-up to seizures, would be advantageous, in this case. **Hospitalizations** To assess the medical providers' participation with acute hospitalizations, the Monitoring Team requested an alpha list of all hospitalizations that occurred during the reporting period, and from that list, for the first and then every fifth individuals, for a	

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		total of ten individuals: • Hospital admission and discharge summary • Copy of medical provider's Doc-to-Doc communication • Nurse liaison follow-up at hospital • Post hospital Nursing Follow-up • Post hospital IPN by the medical provider, through full resolution of the discharge condition Between 2/22/2013 and 7/18/2013, the Facility reported a total of 113 admissions to an acute hospital, averaging 23 admissions per month, and from a list of the reported hospitalizations, reviewed the following information for the first five hospitalizations on the list (Individuals #11, #430, #602, #129 #129, and #207: a. Hospital admission and discharge summary b. Copy of medical provider's Doc-to-Doc communication c. Nurse liaison follow-up at hospital d. Post hospital Nursing Follow-up e. Post hospital IPN by the medical provider, through full resolution of the discharge condition Four out of five examples (80%) included a comprehensive hospital transfer note, completed by the nurse. • There was no form for Individual #129. • Five out of five examples (100%) included comprehensive nurse liaison notes, documented the complete hospital stay. • Five out of five examples (100%) included a comprehensive nurse liaison post hospital discharge note. • One out of five examples (20%) included a note by the medical provider, indicating a post hospital assessment. • One out of five examples (20%) included a note by the medical provider, indicating a Doc-To-Doc discussion with the hospital medical staff. o The Doc-To-Doc note for Individual #129 was comprehensive, and included a detailed overview of the individuals condition • Zero out of five examples (0%) included medical provider's post hospital IPNs, documenting the discharge condition, through resolution. Based on the documented provided for review, the Facility's nurse liaison process is working very well, and enabled excellent continuity of care. The medical provider's documentation of the Doc-to-Doc discussion, and IPNs documenting post hospital follow-up, through resolution of the discharge diagnosis, must be enhanced.	

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		Review of DNRs The Monitoring Team requested a list of all individuals who were currently on DNR status, and for that list, for the last five Individuals: • Most recent medical assessment • Most recent quarterly medical assessment • ISP documented rational for DNR • Copy of ethics review for DNR • Copy of consent for DRN • Copy of specific DNR form • Copy of the medical prescriber's IPN documenting the clinical rationale for the DNR • Copy of specific instruction for staff documenting the specific type of DNR The Monitoring Team was informed by written response to the document request, that the Facility does not provide specific instruction for DNRs, but the DNR status is noted in each record. Following are findings for individuals: Individual #220: • The annual medical assessment stated "has been placed on a do not resuscitate status by family. Resuscitative Status II. (No CPR)." There was no documentation noted on the medical action plan delineating the clinical rationale for the DNR. • The ISP, dated 4/29/2013, stated "has a DNR in place by family. The team discussed the need for the Ethics Committee to meet and review the DNR status. Ethics Committee will review the most current DNR status and make changes if needed." The ISP did not document the rationale for the DNR. • Ethics Committee Meeting Minutes, dated 10/4/2012, stated, "The committee reviewed the DNR status. It is recommended that the DNR remain in place given the following qualifying conditions: Intractable seizure, gastroparesis, congestive heart failure with frequent hospitalizations for pneumonia." • The physician on 10/17/2017 signed the Resuscitative status II form; however, the form did not specify the qualifying condition, as required. Also, the form clearly indicates that the form was designated for a person who has been diagnosed and certified in writing to have a terminal condition by two physicians. Two physicians did not sign the document, or provide a certified condition. • There was no support plan documented on the ISP for the DNR. • The Monitoring Team has the following concern o The annual medical assessment did not include an action plan, or other documentation, indicating the clinical rationale for the DNR. o The most recent ISP did not document the clinical rationale for the DNR, and identify alternative supports to be provided during an end of life event, such	

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		as behavioral, and medical treatments to reduce anxiety, possible pain, and distress. o There were no supports listed for direct staff to adhere to, regarding the DNR. Individual #117 • The annual medical assessment stated "DRN II". There was no documentation noted on the medical action plan delineating the clinical rationale for the DNR. • The ISP, dated 1/22/2013 stated "mother recently obtained a do not resuscitate order", and there was no documentation of the clinical rationale. • There was no support plan documented on the ISP for the DNR. • There was a note, by an external physician who provided the clinical rationale for the DNR status, and an associated IPN by the medical provider that documented a discussion with the external physician. The Medical provider also signed the DNR form, which was also signed by the LAR. • The last ethics committee entry regarding the DNR status was on 12/5/2013, and indicated "Received a message for the (external physician) with a telephone number to set up a call with the (medical provider) and (external physician)". There were no additional committee meeting notes regarding the DNR status. • There was no support plan documented on the ISP for the DNR. Individual #576 • The annual medical assessment dated 10/8/2012 stated "DNR code 1", and there was a comment under the heading "Hospitalizations", on 6/11/2012 that stated "a DNR order was put in place, and the (individual) was to have comfort measures only and to remain in the infirmary on high flow oxygen". The annual medical assessment did not include an action plan, or other documentation, indicating the clinical rationale for the DNR. • The ISP, dated 11/5/2012, stated that the DNR is in place and is on hospice"; however, there was no documentation as to the clinical rationale for the DNR. • There was no support plan documented on the ISP for the DNR. • The Ethics Committee Minutes, dated June 5, 2012 stated that the Individual's "mother requested that a Do Not Resuscitate (DNR) order be put into place for (the individual)", and the committee concurred. There was no meaningful documentation as to the clinical rationale, and other supports that should be considered. There was no subsequent review, or follow-up by the Ethics Committee, regarding the DNR. • The medical provider and the LAR signed the DNR form. • There was an IPN by the medical provider, dated 6/11/2012, documenting a post hospital following, and the need for DNR and comfort measures for pulmonary edema, and history of CHF; however, there was no follow-up documentation to	

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		support the ongoing need for the DNR. • The Monitoring Team has the following concerns: o The annual medical assessment did not include an action plan, or other documentation, indicating the clinical rationale for the DNR. o The most recent ISP did not document the clinical rationale for the DNR, and identify alternative supports to be provided during an end of life event, such as behavioral, and medical treatments to reduce anxiety, possible pain, and distress. o There were no supports listed for direct staff to adhere to, regarding the DNR. o There was no documentation to support the on-going need for DNR. Individual #575 • The annual medical assessment, dated 12/18/2012, stated "Code I. (Full Code)." There was no documentation noted on the medical action plan delineating the clinical rationale for the DNR and necessary supportive measures. • The Ethics Committee Minutes, dated 2/15/2013, indicated an exceptional review, and documentation of the clinical rationale for the DNR. • The medical provider and the LAR signed the DNR form. • There were no IPNs documenting the clinical rationale by the medical provider. • The most recent addendum to the ISP, dated 2/12/2013, stated that the committee would refer the Individual to the Ethics Committee to review the need of a DNR. There were no subsequent ISP addendums to address the Ethics Committee decision. • There was no support plan documented on the ISP for the DNR. • The Monitoring Team has the following concerns: o There was no IPN, or quarterly medical assessment, documenting clinical rationale for the DNR, and identifying necessary supports and services, specific to the DNR. o There was no follow-up ISP addendum to address the Ethics Committee decision for the DNR. o There were no supports listed for direct staff to adhere to, regarding the DNR. Individual #365 • The annual medical assessment, dated 5/30/2013, did indicate a clinical rationale for the DNR that clearly delineated the underlying medical conditions necessitating end of life measures. There was no documentation noted on the medical action plan delineating the clinical rationale for the DNR and necessary supportive measures. • The ISP, dated 5/23/2013, indicated the clinical rationale for the DNR; however, it did not delineate the necessary supports to aid the individual during an end of life	

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		event. • The Ethics Committee Minutes, dated 4/10/2012, stated "the DNR remain in place given the following qualifying conditions: Severe spastic quadriplegia, severe scoliosis, gastric reflux, Barrett's esophagus, osteoporosis, seizure disorder, long time tracheostomy, tracheal diversions." The listed indication was different from the indication listed on the ISP, and the annual medical assessment. A follow-up Ethics Committee Review was held on 4/11/2013, that indicated the reason for the DNR was because of "Severe spastic quadriplegia, severe scoliosis, long time tracheostomy, tracheal diversions". Again, the listed indication was different from the indication listed on the ISP, and the annual medical assessment, which indicated the clinical rationale as "respiratory failure secondary to recurrent pneumonia." • A DNR form was signed by the medical provider and the LAR. • The Monitoring Team has the following concerns: o There was no supports listed for direct staff to adhere to, regarding the DNR, especially during an end of life event. o It was clear that the Ethics Committee did not fully understand the clinical rationale for the DNR. Specific to the DNR process, the Monitoring Team reviews each case to determine the clinical rationale for the DNR, and to ensure that an unbiased review had been conducted and to ensure that appropriate safeguards were in place. The Monitoring Team noted several instances where the clinical rationale for the DNR was not clearly indicated. Also the Monitoring Team recognizes that an end of life event would require pre-planning, especially when a DNR is in place. For example, issues, such as how should staff handled an end of life event when there is an active DNR, should be assertively assessed by the IDT. There were no examples of such planning, or instruction to staff on how to assist the individual during an end of live event. Also, the medical provider must ensure appropriate assessments, and documentation of qualifying conditions, and the ethics committee must diligently review all aspects of each DNR request. Summary: The Monitoring Team recognizes the diligent work by the Facility to enhance medical care to individuals who reside at the Facility. The medical department continues to improve in many areas. The Monitoring Team is especially complimentary for the improved, and much more comprehensive annual medical assessments; the comprehensiveness of the PNMT process; and enhanced efforts for follow-up on pneumonia, decubitus ulcers, and serious injuries. The Monitoring Team also recognizes that follow up to many medical issues, was much more comprehensive, and efficacious, than in the past. Documentation practice has also significantly improved with regards to IPNs being written in the SOAP format, and enhanced documentation of action plans	

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		being documented for each diagnosed condition. Compliance will require further improvements by enhancing clinical management of various medical conditions, including pneumonia, fractures, and seizures. The Facility must also review it process to ensure that indications for DNRs are clinically justifiable, and that the ethics committee, and IDT assertively evaluate the necessity of a DRN, prior to initiating a DNR, and at least annually, thereafter.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	To assess the Facility's development and implementation of a review system that consists of non-facility physician case review to assess the quality of medical care and clinical performance, the Monitoring Team reviewed the external medical audit reports and associated policies and procedures for the medical audit process (DADS Policy: Medical Provider External/Internal Audits, revised July 6, 2012 – no number). Data, data analysis, and summaries developed for the medical provider external and internal audit process were reviewed, as was an undated, and unsigned letter entitled "medical Provider External Review". The Monitoring Team also assessed the Facility's mortality review process **Medical Provider External Review** During the past six months, the Facility conducted round 7 of the medical audit review process on February 21, 2013. For this audit a total of 24 clinical records were reviewed of 484 individuals in the population, a 5% sample as required by DADS procedure for the external audit. • Two out of nine (22%) medical providers attained a Facility determined passing score of 100%, for essential audit items. • Eight out of nine (89%) medical providers attained a Facility determined passing score of 80% or greater, for non-essential audit items. • The Monitoring Team could not identify data, specific for medical management audit items, as they were reported as "medical management compliance by diagnosis", and the following is the reported aggregate for the audited medical providers, of the three medical management audit items: o Osteoporosis 80% o Diabetes 100% o Pneumonia 81% • There were 184 action plans developed for the unsuccessful essential, non-essential, and medical management audit items (total for both internal and external audits). A total of 169 out of the 184 (92%) action items had been completed by the time of this review. The Monitoring Team did not determine what percentage were completed within 30 days following the review but will review that at the next compliance visit.	Noncompliance

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		Medical management audits were conducted for three conditions (pneumonia, diabetes, and osteoporosis); although this meets the requirements of the procedure established by DADS, it did not accurately assess if the provider was practicing at the level of acceptable standard of care. To move toward compliance with this provision, the Monitoring Team recommends additional conditions commonly found in this population must be included in the audits, at least on a rotating basis. Issues such as constipation, aspiration risk, management of enteric tube feeding, neuromotor conditions, musculoskeletal conditions, and syndrome conditions should also be assessed. The Monitoring Team had concerns as to the efficacy of the round 7, external medical provider quality assurance audit, dated 2/21/2013, for example: Many of the evaluation questions did not assess the appropriateness of the provider's action, simply whether the action completed or not. Examples of this issues are as following: • Question #6 "Does the summary include significant medical events of current and past years?" In most cases reviewed by the Monitoring Team, as delineated in the many assessments listed for Section L.1 of this report, the medical provider did indeed document a summary of past events, but the summaries were limited, and did not provide meaningful insight into the event. One example is that of Individual #170, in which a summary was documented for seizure disorder; however, it did not document how well the seizure disorder was controlled, comment or summarize on the frequency of seizures, or summarize the efficacy of treatment for seizure disorder, and there was no specific target frequency identified for seizure control (so the summary could not evaluate frequency against the target frequency). In most cases, the summary was very general. On the other hand, one example of a comprehensive summary of a past medical issue was that of the annual medical assessment for Individual #656, which demonstrated a very detailed summary of the Individual's follow-up with neurology, and the action plan documented relevant clinical treatments. There was a specific section called "Seizures", which documented the frequency of seizures over the past years. The medical action plan was exceptional, and clearly delineated the condition, and medical treatment plan. • Question #9 was to determine if "appropriate immunization been given"; however, there was no question to assess if specific vaccination had been administered, or if the individual was assessed for immunity. • Question #14 assessed "is there evidence that the provider responded to the pharmacists quarterly drug regimen review recommendations", however, there was no question to assess if the provider responded appropriately. The audit	

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		should assess if the medical provider did in fact follow through with the recommendations, in a clinically appropriate manner. A form letter, which was not signed or dated, indicated that a non-Facility physician had conducted the medical provider external review from 2/21/2013 through 2/22/2013, and that a total of 24 complete records and nine disease specific charts were evaluated during that time period. The letter also indicated that the staff remained knowledgeable of their patients' medical issues, and that care provided was thorough and competent. The Monitoring Team review of clinical records, for the purpose of this report, indicated a lack of clinical documentation demonstrating comprehensive management of medical conditions, as necessary in the context of providing medical care to individuals with developmental disabilities. For example, medical providers were not assessing the efficacy of various clinical supports for position, eating, and transfer, and failure in this area could result in an increase in pneumonia; when assessing osteoporosis, it is essential that the medical provider determine potential reversible conditions, such as hypogonadism but the Monitoring Team did not find this being done. The findings of the Monitoring Team were not fully consistent with the conclusions in the letter, perhaps because the audit tool focused on presence or absence of actions but did not assess clinical performance, as it related to acceptable standard of care practice. The medical director provided a letter to the Monitoring Team stating that he reviews the findings of the audit with each medical provider, and includes the findings as a component of a peer review process. **Medical Provider Internal Medical Reviews** The internal medical audits serve as an additional review process to assess the clinical performance of medical providers, during the interim period of the DADS external medical reviews. To assist the Facility conduct its own internal medical reviews, the Facility contracted with a local physician, who does not regularly practice at the Facility, to conduct the audit process, in the same format as the external medical audits are completed. Although described as an internal review, this review consists of non-facility physician review in concert with the requirements of this provision. The same audit elements were used for the internal medical review as listed above under external medical reviews. The following is a summary of the findings from the internal medical audtis: • Four out of 11 (36%) medical providers attained a Facility determined passing score of 100%, for essential audit items. • Eight out of eight (100%) medical providers attained a Facility determined passing score of 80% or greater, for non-essential audit items • The Monitoring Team could not identify data, specific for medical management	

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		audit items • There were a total of 184 action plans developed for the unsuccessful essential, non-essential, and medical management audit items (total for both internal and external audits). A total of 169 out of the 184 (92%) action items completed, by the time of this review. **Mortality Review** 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. The Clinical Death Review Committees' 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 individuals; 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 Nurse Investigator/ Supervisor/Nurse Case Manager responsible for the specific residential area where the deceased individuals lived. The Administrative Death Review Committees' membership, according to policy, included the Facility Director, Medical Director, Chief Nurse Executive, and Public Representative. Since the last compliance review in October 2012, six deaths had occurred. General findings included: • Of the four deaths reviewed by the Monitoring Team, the average age was 53.3 years (ages varied from 36to 64 years of age) as compared to the average age of 67.3 years found at the last review, which was 13.7 years younger. • A review of the Facility's Clinical Death Review Committee and Administrative Death Review Committee Tracking Reports indicated that four of six death reviews were completed, for Individuals #3, #80, #460, and #740 and complied with the Facility's Clinical Death Review Committee and Administrative Death Review Committee Policies. The Monitoring Team's review of the above deaths showed continued improvement. Reviews for recent deaths for Individuals #82 and #443 were in process and not yet due for completion. The Monitoring Team will review these deaths at the next compliance review. • The death reviews completed to date showed: o One of the four (25%) deaths had an autopsy completed. • Zero of four (0%) were reported as unusual deaths.	

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		• Four of four (100%) had Unusual Incident Reports (UIRs) completed related to the deaths. • Three of four (100%) deaths occurred at a hospital. One death occurred at the Facility. • Two of four (50%) decedents' had Do Not Resuscitate (DNR) orders signed. • The cause of four individuals' deaths, as listed on the Death Certificates, are listed in the chart below: 1. Individual #3: Immediate Cause of Death: Pneumonia Underlying Cause of Death: Mental Retardation Other significant condition contributing to death: Hypoxia 2. Individual #80: Immediate Cause of Death: Aspiration Underlying Cause of Death: Ileus Other significant condition contributing to death: Rectal Cancer 3. Individual #460: Immediate Cause of Death: Chronic Obstructive Pulmonary Disease (COPD) Underlying Causes of Death: Dementia and Dysphagia 4. Individual #740: Immediate Cause of Death: Respiratory Arrest Underlying Causes of Death: Status Epilepticus and Lennox-Gastaut Syndrome The Nurse Investigator continued to maintain a tracking system for compliance with the Facility's Clinical and Administrative Death Review Committee Policies and resulting recommendations through to resolution for each death review completed. The Monitoring Team reviewed the Clinical and Administrative Death Review Committee minutes, supporting documentation, and Recommendation Tracking Logs for each death. The Monitoring Team's review of the four deaths' recommendations made by the Clinical and Administrative Death Review Committees found that recommendations for three deaths had been carried out through to resolution. For one recommendation for Individual #740, who recently died, there had not been time for it to be completed. Based on the Monitoring Team's review of the recommendations, while all were appropriate, the responsibilities for carrying out the recommendations were limited to the Medical Director, Chief Nurse Executive, Respiratory Therapist Director, Facility Director or designee, Quality Assurance Director, and Nurse Investigator. There were no recommendations related to other disciplines, or nor were there systemic recommendations. To fulfill their purpose of identifying improvements to be made to care, death reviews must be thorough, systematic, and integrated. The Nurse	

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		Investigator explained that the Facility's death reviews were a medical peer review process. Therefore, other disciplines were not included. Nevertheless, meaningful recommendations can be developed for all disciplines, while maintaining a peer review process. The Monitoring Team did note that the review of medical issues, including possible contributing factors to the death, were much better delineated, and enabled a better insight of clinical care issues, not only around the time of death, but longitudinally, The clinical review process would be enhanced if all relevant clinical supports and services were assessed for efficacy, by the medical provider. 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. The Facility provided a document titled "DSSLC Analysis of Death." The report summarized deaths from June 2009 through May 2013. The information included: number of deaths, death rate, average age, age range, normal weight, over weight, under weight, DNR, hospital (guess number that died in the hospital?), and causes of death. There was no other documentation provided regarding how the facility used this information. It was positive to find that the Facility had completed a longitudinal analysis of deaths occurring from June 2009 thorough May 2013. However, there was no documentation supplied that showed how this information was used to track and trend systemic issues, develop corrective action plans, or the efficacy of the corrective actions. 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. Summary: The Facility conducted regularly scheduled internal and external medical audits, to help assess the clinical performance of physicians. Action plans were developed, implemented, and tracked to completion. The Facility must enhance the medical audit process by ensuring that a medical management elements are developed for the most common, and most serious medical conditions that occur in people with intellectual disability; that a sound sample of records are reviewed for each audit; and that the results of the audits are used by the Facility to help enhance and monitor physician	

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		performance. In addition to process, the audits should assess the quality of items being audited. The Monitoring Team was pleased to learn that the medical director utilizes the medical audit process as a component of peer review, and that he discusses the results with each respective The Monitoring Team's review of the Facility's mortality review process, noted improvement since the last review, however, the Facility must enhance its process further, in order to ensure that meaningful recommendations that lead to systems improvements occur. Also, the clinical review must better assess all contributing factors that may have played a role in the death. For example, when following up on an pneumonia related death, the committee should determine if the medical provider assessed the efficacy of supports.	
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 ability to develop and implement a process for medical quality assurance, that it collects clinical data, and conducts trends analysis of clinical outcomes, the Monitoring Team discussed the Facility's medical quality assurance process with the medical director, and reviewed the following documents: • Medical Quality Assurance, Med-01 Exhibit H, dated July 1, 2013 • Action plan related to clinical indicators, October 2012 – June 2013 • DSSL QA/QI Council Meeting Data Analysis Report for January 2013, through June 2013 • Internal Health Service Compliance Audits for January 2013, through June 2013 **Internal Health Service Compliance Audits** The medical quality assurance policy: Medical Quality Assurance, Med-01 Exhibit H, dated July 1, 2013 was reviewed. The policy indicated that, in addition to completing internal medical audits, the Facility is to maintain a Health Services Compliance Coordinator (HSCC) Medical Record Audit, to assess the quality of DSSLC medical care and clinical documentation. In addition, the policy requires the audit of two "Medical Records" for each provider, monthly. The audit focused on documentation related to completing the Annual Physician Summary, and supporting documentation, such as: consults, timely completion of the annual physician summary, and the active problem list. The Monitoring Team reviewed completed HSCC record audits for the reporting period. The audit form was a grid that listed 12 audit items, that included items such as timeliness of reports; completeness of reports; were consultation reports reviewed by the provider; and if action plans were developed for all active problem listed on the annual physician summary. There was a completed form for each medical provider, for the six-month reporting period, totaling 12 individuals per full-time provider; however, there was no associated completed data report, or data analysis, and the QA/QI report	Noncompliance

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		dated January 2013, only indicated that "plans and recommendations on the annual physician summary addressing all relevant active problems continue to need improvement." There was no specific data reported for specific issues being assessed, and there was no summary of the data, data analysis, or reported action plans for all deficient items. This process is an excellent beginning of a system to monitor processes as well as outcomes, and to supplement the non-facility physician reviews with a broader and ongoing sample. The Monitoring Team will look closely at the progress of this process and how it leads to actions to address areas of needed improvements identified through these audits. The medical director informed the Monitoring Team that he utilizes data derived from the HSCC audits to ensure that annual medical summaries, quarterly assessment, and follow-up to consultations, among other tasks, are completed timely, and when a deficiency is noted, he can address it with the clinical staff. The Monitoring Team recognizes the benefit of this audit process and is complimentary to the Facility for its diligence of routinely monitoring clinical activity for completeness, and timeliness; to move toward achieving compliance, the Monitoring Team recommends the Facility implement and document a more complete analysis of all related tracked data, and specific action plans, and follow-up to action plans, at the Monitoring Team's next on-site review. **Medical Quality Assurance Process** The Monitoring Team was provided a copy of clinical indicators, dated May 2013, that included 73 clinical parameters, such as: ER visits, hospitalizations, pneumonia, aspiration pneumonia, loss of mobility, among others. The indicators are items used by the QA/QI department, to develop tracking and assessment measures. Review of the DSSLC QA/QI Council Meeting Minutes for January 2013 through June 2013, indicated that that tracked data for the clinical indicators, such as the incidence of pneumonia, UTIs, serious injuries, and loss of mobility, among many others, had been collected longitudinally, and analyzed quarterly by the QA/QI department and QA/QI Council. In addition, there was evidence to indicate that the data was analyzed, and that there were action plans, and follow-up to actions developed for outstanding issues. During the Monitoring Team's discussion with the medical director the Monitoring Team was informed that he reviews the results of all tracked data, and trends analysis, and utilizes the information for the purposes of enhancing processes to improve medical services. Examples of the medical director's utilization of this data include: o Having identified the incidence of pneumonia as a concern to be addressed, the Facility developed a robust process improvement program to help address pneumonias. For example, the Facility developed a consulting arrangement with a pulmonologist, who is currently reviewing all cases of recurrent pneumonia,	

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		and report aspiration pneumonia. In addition, the Facility now reviews all cases of pneumonia as a component of a PNMP review. o Results helped guide the PNMT in the direction of increased incidence of adverse conditions. For example, when learning of the incidence of decubitus ulcers, the PNMT started reviewing each case of decubitus ulcer, to help determine the etiology, and mechanisms that help reduce the incidence of decubitus ulcers, Subsequently, as reported in section M.1, of this report, the Facility enhanced their monitoring and reporting of pressure related wounds, and for this reason, the reported incidence of decubitus ulcers was increased; however, the Facility was better able to determine the how the wound developed, and it was realized that the majority of pressure wounds occurred while the Individuals were hospitalized for an acute medical condition. For example, in June 2013, a total of ten pressure ulcers were identified, and reports, and nine out of ten (90%) occurred while the individuals were hospitalized, and not at the Facility. Since learning of these trends, the Facility had recently developed a plan to enhance surveillance of pressure wounds when individuals are transferred to an acute care hospital, and conducted meeting with the acute care hospital to develop a collaborative approach to help identify, and reduce risks for pressure wounds. The Monitoring Team compliments the Facility for its ongoing development and evolution of an comprehensive medical quality assurance process, and equally impressed with how medical services has taken steps to utilize the information gleaned through its reviews of medical quality assurance data, to improve services Summary: The Facility developed, and implemented a data-driven process to track, and trend medical outcome indicators, for the purpose of enhancing clinical care at the Facility. Outcome indicators were well considered, and include topics such as pneumonia, other respirator infections, fractures, and other injures, and management of diabetes, among many others. Data is maintained by a functional electronic database system, and regularly analyzed for trends. Data and trends analysis were reviewed as a component of the Facility's robust QA/QI program, and along with recommendations for process improvements, were incorporated into a comprehensive QA/QI report. There was evidence to support that the medical director utilizes the QA/QI report to develop processes to enhance clinical outcome. However, the Facility did not demonstrate that the process is yet structured and formalized enough so that issues needing to be addressed will routinely be evident and actions documented. The Facility has made substantial progress toward development of an effective medical quality assurance system. To move toward substantial compliance, the Facility needs to ensure there is a routine structured review of both outcomes data and the findings of the HSCC review regarding processes, identification of issues to address, development of actions to	

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		address those issues, review of effectiveness, and revision of actions as needed. The Facility has begun to implement these, has early examples in practice, and is well on its way to achieving this. The Monitoring Team looks forward to reviewing continued implementation and evolution to a compliant system.	
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.	To determine if the Facility's policies and procedures help ensure that the quality of medical services is at the level of standard of care practice, the Monitoring Team request a copy of the Facility's medical policy and procedure, and a copy of all new and updated policies for medical care, and the Monitoring Team was provided: • DADS Medical Care Policy: 009.2, dated 5/15/2013, • DSSLC Policy Medical 01 – Medical Care; Process for Consultations, dated July 1, 2013 • DSSLC Policy Med- 1; Medical Quality Assurance, dated July 1, 2013 DSSLC Policy Med- 1; Medical Quality Assurance The DSSLC Policy Med- 1; Medical Quality Assurance, dated July 1, 2013 was reviewed for Provision L.3, of this report. DSSLC Policy Medical 01 – Medical Care; Process for Consultations, dated July 1, 2013 was noted to delineate the entire consultation process, enabling the reader to understand how consultations are ordered, scheduled, followed up on, and tracking of missed appointments. DADS Medical Care Policy: 009.2, dated 5/15/2013, was noted to be comprehensive, and oriented to the practice of developmental disability medicine. The Monitoring Team noted that the policy addressed all relevant issues, including documentation, provision of medical care, follow-up on acute and chronic conditions, participating in the interdisciplinary team process, maintaining active problems list, liaison with community hospital, and consultants, among many other issues . For sections I through V, and IX through X, the Monitoring Team strongly concurs with the policy, and is complimentary to the central office for developing a developmental disability centered policy for the provision of medical care. The Monitoring Team does have some reservation with sections VI through VIII, noting that requirements, outlined for providing medical care for specific clinical conditions, could be confusing to the medical provider, as they do not represent actual clinical pathways that are DD specific. For example, section VII, which deals with aspiration pneumonia, stated, "the goal is to reduce the risk of aspiration pneumonia, as a reference, see medical resources", and "expectations are for the individuals to enjoy maximum participation in daily life	Noncompliance

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		activities". While both statements are important, they do not provide specific guidance, or necessary expectations, for the management of aspiration pneumonia, and in the context of a DD setting. Specific pathways, which are DD specific, should be developed for the most common and significant clinical conditions that occur in individuals with developmental disabilities. The Monitoring Team was unable to fully assess if the Facility was substantially following the medical care policy; however, the review did note that for several areas, medical providers were not adhering to the new policy, which is fully understandable, since the policy had only been recently introduced. Some examples of not adhering to the policy include: • Medical providers not following up daily on acute issues until stabilized or resolved. • Medical providers did not document the clinical issues, as instructed by the policy. • Medical providers were not assertively attempting to help minimize the risk of recurrence or exacerbation of a medical condition. • Medical orders did not list monitoring parameters, and what changes needed to be brought to the attention of the PCP. Summary: The Monitoring Team reviewed, and concurred with the Facility's new policies for medical consultations, and medical QA/QI, and is complimentary to the central office for developing a robust policy to address many medical issues, as delineated by its new medical policy. Compliance will require that the policy become substantially implemented at the Facility. The Monitoring Team recommends that the central office develop clinical pathways that are DD specific, for the most common, and significant medical conditions that occur within the context of a DD Facility.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Section M Self-Assessment, Updated: 7/8/13 2. DSSLC Section M Action Plans, Updated: 6/21/13 3. DSSLC Section M Provision Action Information, Updated: 6/25/13 4. DSSLC Section M Presentation Book 5. Texas Department of Aging and Disability Services (DADS), State Supported Living Center, Nursing Services Policy: Policy Number: 010.3, Effective: 6/7/13, Replaces: 010.2 6. DADS State Supported Living Center Procedure: Medication Administration Guidelines, Date: June 2013 7. DADS State Supported Living Center Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Date: April 2013 8. DADS Guidelines for Major Medication Review, Date 3/13/13 9. DSSLC At Risk System, Policy Number: CM 14 – Addendum H, Effective: 2/1/13 10. DSSLC Pharmacy and Therapeutics Committee, Policies and Procedure Manual, Committee and Councils – 05, Date: 4/10/13 11. DSSLC Polypharmacy Review Committee, Policy and Procedure Committees and Councils – 10, Date: 2/7/12 12. DSSLC Anticholinergic Policy and Procedure, Pharmacy Policy – 49, Revised: 4/10/13 13. DSSLC Benzodiazepine Policy Guidelines, Pharmacy Policy – 48, Date 6/1/11, Revised: not noted 14. DSSLC STAT Medication Policy and Procedure, Pharmacy Policy - 50, Revised: 4/10/13 15. DSSLC Process for Adverse Drug Reaction Reporting, Pharmacy Policy – 34.1, Revised: 2/28/12 16. DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy – 27.1, Revised: 4/4/13 17. DSSLC Guide to Medication Storage, Pharmacy Policy – 36, Date: 6/21/11 18. DSSLC Division of Nursing, Hand Hygiene Policy, Reviewed/Revision Date: 3/19/12 19. DSSLC Clinical Practice Guidelines for Clostridium Difficile Infection in Adults, 2/26/13 20. DSSLC Clostridium Difficile Management Protocol, 7/11/13 21. DSSLC General Guideline for Staff Providing Care at a Hospital, no date 22. DSSLC Campus Map 23. DSSLC Nursing Organizational Chart 24. DSSLC Nursing Monthly Staffing Patterns for all Units and Infirmary, October 2012 through May 2013 25. DSSLC Summary/Analysis of Nursing Monthly Staffing Report for all Units and Infirmary, October 2012 through May 2013 26. DSSLC Nursing Monthly Full Time Equivalents Report, August 2012 through June 2013 27. DSSLC Nursing Monthly Overtime Hours Report, September 2012 through June 2013 28. DSSLC Nursing Monthly Contract Hours Report, August 2012 through May 2013 29. DSSLC Nursing Monthly Schedule for all Units and Infirmary and for all shifts, July 2013 30. DSSLC Nursing Meeting Schedule Week of July 22 through July 26, 2013 31. DSSLC Skin Integrity Nurse Responsibilities in Meeting Facility Priorities 32. DSSLC Nurse Manager Meetings, 12/20/12, 1/28/13, and 2/27/13 33. Nursing Compliance Meeting Minutes, 5/30/13

	34. DSSLC RN Case Manager Staff Meeting Minutes, 4/1/13 and 5/13/13 35. DSSLC 10-6 Nurses Meeting Minutes, March 2013 and May 2013 36. DSSLC Infirmary Unit Nurses Meeting Minutes, 12/12/12, 1/16/13, 2/13/13, 3/13/13, 4/17/13, and 5/15/13 37. DSSLC Cedar Falls and Houston Park Unit Nurses Meeting Minutes, 3/22/13, 4/17/13, and 5/15/13 38. DSSLC Eastfield and Timberhill Unit Nurses Meeting Minutes, 1/23/13, 2/13/13, 3/27/13, 5/1/13, and 5/22/13 39. DSSLC Westridge and Garden Ridge Unit Nurses Meeting Minutes, February 2013, 3/27/13, 5/21/13, and 6/5/13 40. DSSLC Quality Assurance/Quality Improvement (QA/QI) Council Meeting Minutes for Data Analysis Reports, 9/18/12, 2/5/13, 4/30/13, 5/28/13, 6/18/13, and 7/23/13 41. DSSLC List of Nursing Data Monitored/Audited and Staff Responsible for Data and Continuous Improvement (CQI) 42. DSSLC Monitoring Process for Section M – Nursing 43. DSSLC Physical, Nutritional, and Management Committee Meeting Minutes, 1/3/13 through 7/11/13 44. DSSLC Pharmacy and Therapeutics Committee Current Membership 45. DSSLC Pharmacy and Therapeutics Committee Meeting Minutes, 10/9/12, 11/27/12, 1/29/13, 2/26/13, 4/3 and 4/10/13, and Agenda for June 2012 but no minutes included 46. DSSLC Medication Administration/Variance Pre-Committee Meeting Minutes, 1/14/13, 2/19/13, 3/20/13, 4/26/13, and 5/17/13 47. DSSLC Medication Administration/Variance Committee Meeting Minutes, 11/19/12, 1/16/13, 2/27/13, 3/25/13, 4/24/13, 5/22/13, and 6/21/13 48. DSSLC Medication Variances June 2012 through May 2013 49. DSSLC Monthly Medication Administration Observation Data and Corrective Action Plans(CAPs), November 2012 through April 2013 50. DSSLC Medication Excess/Shortage Form 51. DSSLC Return without Justification Report Form 52. DSSLC Medication Storage Inspection Summary Form 53. DSSLC Responding to Hazards and Emergencies Curricula and Training Materials 54. DSSLC Drill Instructions for Drill Instructors/Observers 55. DSSLC Drill Meeting Minutes, 10/26/12, 11/28/12, 12/30/12, 1/29/13, 2/25/13, and 3/26/13 56. DSSLC Emergency Response/Drill Committee Membership 57. DSSLC Emergency Response/Drill Meeting Minutes, 10/29/12, 11/28/12, 12/21/12, 1/29/13 2/25/13, 3/26/13, and 6/24/13 58. DSSLC Incident Management Review Team Meeting Notes/Log 10/16/12 through 6/6/13 59. DSSLC Competency Development and Training Due/Delinquent Report for Cardiopulmonary Resuscitation (CPR) Basic and CPR for Healthcare Providers, Printed: 7/9/13 60. DSSLC Infection Control Reports, 10/25/12, 11/15/12, 1/10/13, and 4/11/13 61. DSSLC Infection Control Prevention and Practices Curricula and Training Material, 12/23/11 62. DSSLC List of Antibiograms per Month, January 2013 through April 2013 63. DSSLC Adenosine Triphosphate (ATP) Swab Tracking Report, 7/10/13 64. DSSLC Handwashing Case Studies using Hygiena ATP Monitoring Swabs, 5/13/13

	65. DSSLC Infection Prevention and Control Newsletter, Hand Hygiene Saves Lives, Volume 2, Issue 3, 5/14/13 66. DSSLC Infection Prevention and Control Newsletter, Dehydration in the Elderly, Volume 2, Issue 5, 6/26/13 67. DSSLC Competency Development and Training Due/Delinquent Report for Infection Control, Printed: 6/3/13 68. DSSLC Percentage of Individuals Current with Flu Vaccinations 69. DSSLC Percentage of Individuals Current with Tuberculosis (TB) Skin Testing and/or Converter Follow-up 70. Percentage of Employees Current with Flu Vaccinations 71. DSSLC Percentage of Employees Current with Tuberculosis (TB) Skin Testing and/or Converter Follow-up 72. Percentage of Employees Current with Hepatitis B Vaccinations 73. DSSLC List of Infection Control Monitoring Tools 74. DSSLC Procedure for conducting Infection Control Monitoring Functions 75. DSSLC Lists of Staff who Perform Infection Control Monitoring Activities, Frequency Conducted, and How and by Whom Data Analyzed 76. DSSLC Pandemic Respiratory Infectious Disease Readiness Plan, 9/1/09 77. DSSLC Infirmary Admissions, 7/9/12 through 6/14/13 78. DSSLC Emergency Room Report for the past six months 79. DSSLC Hospital Admission Report 10/2/12 through 6/7/13 80. DSSLC Pneumonia Tracking Report October 2012 through May 13, 2013 81. DSSLC Health Risk Report for all 22 Risk Categories for All Individuals 82. Sample Review of Comprehensive Records for 25 Individuals: Individuals #365, #279, #392, #242, #123, #331, #791, #783, #553, #228, #239, #379, #566, #34, #95, #694, #171, #605, #531, #665, #244, #704, #735, #463, and #304 83. Sample Review of Community Placement Nursing Summaries and Discharge Packets for six Individuals: Individuals #81, #183, #122, #763, #67, and #359 84. Sample Review of Active Skin Integrity Issuers for six Individuals: Individuals #323, #734, #392, #583, #750, and #242 85. Sample Review of Ten Most Recent Reported Medication Variance Reports for Individuals #498, #28, #214, #382, #415, #30, and #56, (#56 had four Medication Variance Reports) 86. Sample Review of Records of five Active Infections for Individuals #211, #242, #719, #164, and #587 87. Sample Review of Reports of five Reportable Infectious/Communicable Diseases for Individuals #552, #719, #551, #587, and #750 88. Sample Review of 12 Hospital Liaison Nurse Records for Recent and/or Currently Hospitalized Individuals #86, #148, #576, #170, #279, #423, #760, #750, #654, #769, #198, and #551 89. Sample Review of 15 Records Related Diagnoses of Diabetes for Individuals #367, #335, #276, #517, #753, #35, #89, #19, #401, #331, #402, #490, #560, #90, and #395 90. Review of Records Related to Follow-up on Unusual Incident Reports for Individuals #642, #285, and #295 **People Interviewed:**

	1. Delia Schilder, RN, Chief Nurse Executive (CNE) 2. Sherri Courtney, RN, Nursing Operations Officer (NOO) 3. Sibylle Graviett, RN, Compliance RN 4. Diane Porter, RN, RN Case Manager Supervisor 5. Sharon Lancaster, RN, Hospital Liaison Nurse 6. Amber Shotts, RN, Hospital Liaison Nurse 7. Calista Aston, RN, Skin Integrity Nurse 8. Maria Palenzuela, RN, Infection Control Preventionist (ICP) 9. Emily Seago, RN, Diabetic Nurse Educator 10. Linda Barnett, RN, Nurse Educator 11. Gwen Weiss, RN, Nurse Educator 12. Susan Hyde, RN, Nurse Manager, Cedar Falls 13. Hilda Clemente, RN, Nurse Manager, Eastfield and Timberhill 14. Dawn Jones, RN, Nurse Manager, Eastfield and Timberhill 15. Traci Carroll, RN, Nurse Manager, Infirmary 16. Tami Selby, RN, Nurse Manager, Westridge 17. Staci Kraus, RN, Physical Nutritional Management Team (PNMT) Nurse 18. Sara Hart, RN, Case Manager 19. Numerous RN and LVN Staff Nurses **Meeting Attended/Observations:** 1. ISP Meeting for Individual #441, 7/22/13 2. Integrated Morning Meeting/Report, 7/23/13 3. Poly-Pharmacy Meeting, 7/23/13 4. Pharmacy and Therapeutics Committee Meeting, 7/23/13 5. QI/QA Council Meeting, 7/23/13 6. Meeting with Emergency Response Lead Staff: Deborah Salman, Risk Management Director, Allana Garrison, Quality Assurance Nurse Supervisor, Susan Hart, Risk Manager, David Anderson, Safety Specialist, CNE, and NOO, 7/23/13 7. Integrated Morning Meeting/Report, 7/24/13 8. Critical Incident Meeting Regarding Individual #443, 7/24/13 9. Medication Administration Observations in Cedar Falls at 12:00 noon, 7/23/13 10. Medication Administration Observation in Westridge at 12:00, 7/24/13 11. Medication Administration Observation in Timberhill at 4:00 p.m., 7/24/13 12. Medication Variance Committee Meeting, 7/24/13 13. Death Review Meeting with Medical Director, Nurse Investigator, Health Service Compliance Officer, CNE, and NOO, 7/25/13 14. Physical and Nutritional Management Committee (PNMC) Meeting, 7/25/13
	Facility Self-Assessment: For Section M, in conducting its Self-Assessment, the Facility: ▪ Used the statewide Facility Self-Assessment Monitoring Tools. The monitoring/audit tools the Facility used to conduct its Self-Assessment included: Data analyses of nursing vacancies and staffing levels

	nursing over time and agency nursing hours, infection control, skin integrity, emergency response, nursing monitoring tools, medication variances, along narrative explanations for items assessed for each Provision. These data provided sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ The data reported included sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. ▪ The Self-Assessment identified the sample(s) sizes. ▪ The monitoring/audit data used in the Self-Assessment had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results The following staff/positions were responsible for completing the audit tools: The Compliance Nurse, RN Nurse Case Manager Supervisor, Specialty Nurses, Nurse Managers, and Quality Assurance Nurse. ▪ The staff responsible for conducting the audits/monitoring were considered competent in the use of the tools and were programmatically competent in their relevant area(s). ▪ Sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the Nursing Care Monitoring/Audit Tools and Medication Administration Observation Tools. ▪ The Facility used other relevant data sources and/or key indicators and/or outcome measures. For example, these included databases that showed the percentage of compliance with assessments, percent of nurses who had completed training classes, and number of pressure ulcers. ▪ The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress. The indicators clearly identified what was being measured or the criteria used for measurement. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the Nursing Department. The Facility's Self-Assessment stated they were not in compliance with Provisions M.1, M.2, M.3 and M.5 and were in substantial compliance with Provisions M.4, and M.6; the Monitoring Team concurs with their findings. For the provisions that were not found in substantial compliance, the Facility's Action Plans addressed plans for each provision that should assist them to move forward toward substantial compliance in the near future.
	Summary of Monitor's Assessment: Based on the Monitoring Team's review, Provisions M.4 and M.6 were found in substantial compliance. Provisions M1, M2, M.3 and M.5 were not found in substantial compliance. The Nursing Department showed progressive progress in Section M Provisions, more so in some than others. For Provision M.2, the guidelines for admission annual, and quarterly nursing assessments were recently revised and continuing to evolve toward compliance. The same was true for Provisions M.3 and M.5 due to recent revisions to the ISP, Integrated Risk Rating, and Integrate Heath Care Plan processes and forms. There were no provisions found to regress.

	Provision M.1 contained multiple requirements. If the requirements for staffing Hospital Liaison Nurses, Infection Control, and Emergency Response activities were standalone activities they would be considered in substantial compliance. Other requirements for documentation and assessment of acute change of status and skin integrity showed progress but continue to need improvements in order to be considered in substantial compliance, as reflected in the report. Provision M.2 showed that the Nursing Department recently revised the guidelines and forms for conducting annual and quarterly nursing assessments. The RN Case Managers were adapting to and implementing the new guidelines and forms, which were too recently changed to adequately assess the nursing assessments for quality and compliance. Provisions M.3 and M.5 showed the Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. These processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance. Provision M.4 showed a robust competency based educational program that tracked all required training to ensure the training was completed. There was evidence through interviews with nursing administration and management staff, and individuals' records reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed. Provision M.6 showed significant progress in all aspects of medication administration practice according to current generally accepted standards of practice. The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.

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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.	Monitoring Team's Findings: The Facility's Provision M.1 Self-Assessment stated they were in compliance with this Provision but the Monitoring Team did not concur. 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 significant 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 compliance. This Provision of the Settlement Agreement includes a number of requirements that addresses various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response	Noncompliance

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		system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2 and M.3 reports. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of the report. Information and recommendations regarding nursing documentation for the death review process is reported above in Provision L.2. <u>Staffing:</u> At the time of the compliance review, DSSLC had a census of 484 individuals. Since the last review, DSSLC had a total of allocation of 218.3 nursing positions, of which 130.30 positions were allocated for Registered Nurses (RNs), and 88 positions for Licensed Vocational Nurses (LVNs). There were 108 RN positions filled with 22 vacant positions, and 82 LVN positions filled with six vacant positions. Four of the RN positions were allocated to other departments. The Chief Nurse Executive (CNE) and Nursing Operation Officer (NOO) were not included in the total allocation of nursing positions. Despite the vacancies, primarily for direct care nurses, the Nursing Department had remained relatively stable. The Nursing Administration, Management, and Specialty Nurses continued to remain stable, highly motivated and dedicated to providing high quality nursing services. The Nursing Department continued to have experienced and competent administrative, management, and specialty nurses, e.g., Compliance Nurse, RN Case Manager Supervisor, Skin Integrity 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. There had been some changes in the positions for management and specialty nurses. The changes were made through promotions of incumbent nurses that included: The Compliance Nurse (a newly created position), RN Case Manager Supervisor, Skin Integrity Nurse, and Diabetic Educator Nurse. The promotions to higher level nursing positions demonstrated Nursing Administration's exemplary leadership practices by preparing, nurturing, and providing incumbent nurses opportunities for advancement into higher levels of nursing responsibility. In addition, incumbent promotions foster morale and retention of valuable nursing assets. However, there had been turnover and replacement of four RN Case Managers due to staff promotions. At the time of the compliance review there was one vacant RN Case Manager position. Refer to information reported below in this Provision related to specialty areas of nursing practice. The Nursing Department continued to monitor nursing staffing patterns and established nursing ratios for the Units and Infirmary daily on each shift. Staffing levels were reviewed daily prior to each shift by House Nurse Supervisors. In addition, the Nurse Managers continued to meet daily with the 6-2 shift House Nurse Supervisor to review staffing and assist with covering Units when needed by sending nurses from over-covered areas to areas of need.	

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		Staffing patterns and ratio data were analyzed and reported monthly, as well as overall for the last six months. The analysis of staffing data, October 2012 through May 2013, identified trends in staffing patterns that needed improvement, and implemented interventions to ensure adequate coverage, such as Nurse Managers assisting with finding coverage, Nurse Managers staying until safe coverage was established, Nurses being reassigned from other duties to direct care, and Charge Nurses, Specialty Nurses or Nurse Managers providing coverage. In addition, Nurse Managers continued to evaluate staffing ratios as changes in population, acuity, and logistics were identified per Unit. The Nursing Department also continued to conduct an ongoing evaluation to determine the need to reallocate nursing positions to better meet individuals' nursing care needs. The Monitoring Team's review of the nursing staffing patterns and ratio reports since the last compliance visit found they were consistent, as reported in the Facility Self-Assessment. From October 2012 through May 2013, staffing ratios were met consistently with 92.5% to 94.1% accuracy to the "least" acceptable staffing numbers. Nursing Administration continued to monitor monthly the use of overtime and contract agency hours. The monitoring data supplied for the last 18 months appeared to correlate with the monthly number of nursing vacancies. The Nursing Department continued to actively recruit nursing personnel. When possible, employment fairs were attended by key nursing personnel, e.g., AZ Republic Nursing Hand Healthcare Career was attended on 3/12/13. An ad for available nursing positions was placed in the Tennessee Nurses Association (TNA) Quarterly Publication, vol. 7, no. 1, page 9. In addition, the Nursing Administration continued efforts to enhance retention through a preceptor program, which assigned an experienced nurse to each newly hired nurse to reinforce learning during their orientation period. Refer to Provision M.4 for retention efforts made through the use of a preceptor program. The Monitoring Team's review of Nursing Meeting Minutes since the last reviewed showed that meetings were conducted routinely, at least monthly, by Nurse Managers and RN Case Manager Supervisors, and were substantive in content, keeping the nursing staff up-to-date on relevant issues, issues that needed continued improvement, e.g, medication variances, reinforcement of training pertinent areas of practice, and provided positive feedback to nursing staff on areas of accomplishment, as well as on areas of practices that needed continued improvement. It was positive for the Monitoring Team to find that each management and specialty nurse had comprehensive and detailed job descriptions of their respective nursing responsibilities/duties in relation to Facility priorities. In addition, each respective responsibility/duty was correlated with specific Facility priorities and specific Provisions of Section M of the Settlement Agreement. The priorities included: Protection from Harm; Assessments; Knowledge of Settlement Agreement and Intermediate Care Facility (ICF) Standards; and Implementation of specific assigned responsibilities/duties. The identified	

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		responsibilities/duties for each management and specialty nurse are reflected throughout the various Provisions of the Monitoring Team's report. <u>Quality Assurance Efforts:</u> Since the last compliance review, the need for a Compliance Nurse was identified. The position was filled on 4/1/13 by the former RN Case Supervisor. This was a much-needed nursing position to assist the Nursing Department move forward with coordinating and overseeing quality assurance activities. The appointment of the Compliance Nurse was timely because of the significant changes made to the nursing monitoring tool process since the last compliance review. The Compliance Nurse provided a copy of her job description for review. Job responsibilities included but was not limited to the following: • Collaboration with the RN Case Manager Supervisor to establish evaluation criteria for completion of monitoring process for RN Case Managers' assessments and other related activities. • Collaboration with Nurse Management team to establish monitoring processes for nursing activities to improve or maintain services. • Establish inter-rater criteria for monitoring processes. • Attending various meetings, workgroups, committees to utilize and build on current processes related to care of individuals and established procedures, guidelines, processes, and protocols. • Developing action plans and corrective action plans (CAPs) to address identified issues. • Monitoring and tracking completion of CAPs and assigned training. These activities were designed to result in a more integrated approach and better outcomes for the care of individuals served and to maintain and/or improve current processes. The Monitoring Team's review of the 5/30/13 Nursing Compliance Meeting Minutes validated the Compliance Nurse had begun carrying out the above mentioned job responsibilities. The Monitoring Team was provided a copy of the Monitoring Process for Section M – Nursing. The process described the following: <u>Protocol Card Audits:</u> • The number of Protocol Card Audits to be completed monthly by the Unit Nurse Managers, other specific audit instructions, process of sending completed tools to the QA analyst and follow-up corrective actions. Eight of the 23 protocol cards were selected for audits, as mentioned below; other protocol cards may be selected for auditing as Nursing Administration identifies issues that need addressed. Protocol Card Audit Tools will be revised to incorporate an Acute Care Plan portion to the tools used, with the exception of PICA Protocol Card Audit Tool. <u>Medication Administration Observations Audits:</u> • The QA Nurse assigned each Unit Nurse Manager four medication observation passes per month. The QA Nurse completed a set number of Medication Administration	

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		Observations. In addition, the Unit Nurse Managers were assigned to complete one medication administration observation for their respective areas by the QA Nurse for inter-rater reliability. The QA Nurse processes the completed medication administration observation forms, reports the results in the Nursing Medication Variance Committee meeting monthly, and provides the information to the QA Department. <u>Other Monitoring Tools Available for Use:</u> • Urgent Care/ER/Hospitalizations: The Data Analyst provided a sample list to the QA Nurse, who then assigned two monitoring tools each to the Infirmary Director and each Hospital Liaison Nurse. When the tools were completed they notified the QA Nurse. The QA Nurse conducted an inter-rater reliability check within 24 to 72 hours later. The completed tools were submitted to the Data Analyst for processing. The QA/QI Report provided documentation, analysis, and trending information. • Annual Nursing Assessment: Effective 6/1/13, the RN Case Manager Supervisor and Compliance Nurse each completed four assessments. The individuals were chosen from the current monthly ISP calendar (preferably from a different caseload). Adjustments were made as the process was implemented and evaluated. The results of the Annual Nursing Assessment monitoring data were not yet available for review. • Integrated Health Care Plan (IHCP): This monitoring tool was not in use. • Infection Control Real Time Monitoring/Infection Control. This monitoring tool was not in use. • Pain Management: This monitoring tool was not in use. • Skin Integrity: This monitoring tool was not in use. If issues were identified at any time in any of the above categories, substitution of monitoring can be utilized. Since the last compliance review, effective 3/15/13, the Nursing Department started auditing eight of the 23 implemented protocol cards to audit. Protocol Card Audit Tools included: Urinary tract Infections, Pre-Treatment and Post-Sedation, Seizure Activity, Status Epilepticus, Respiratory Distress/Aspiration, Vomiting, Antibiotic Therapy, and PICA. As reported in the Facility Self-Assessment, baseline data was being established. The Nurse Managers were completing two tools for each Protocol Card Audit Tool, unless they did not have an incident requiring the implementation of specific protocol cards by the third week of the month. By the fifth day of the new month the data analyst received the completed tools for data entry and processing. Completed graphs with accompanying information regarding percentage of compliance scores for each tool audited were sent for processing (review and corrective action for tools/items falling below the standard compliance of 85%) to the Compliance Nurse. In addition to the eight Protocol Card Audit Tools, the Nursing Care Monitoring Tool for Urgent Care, ER, and Hospitalization was included in the audits and data reported. The Monitoring Team's review of the QI/QA data results for the overall average percentage of	

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		baseline compliance for Nursing Documentation on eight Protocol Card Audit Tools and Urgent Care, ER, and Hospitalization Tool for March, April, and May 2013 showed:	

Protocol Card Audit Tool	Percentage of Compliance
Antibiotic Therapy	93%
PICA	68%
Pre-Treatment and Post-Sedation	65%
Respiratory Distress	75%
Seizure Activity	67%
Status Epilepticus	85%
Urinary Tract Infections	71%
Urgent Care, ER, and Hospitalization	53%
Vomiting	74%

According to the Facility Self-Assessment and interviews with the CNE and Compliance Nurse, the sample size of tools audited was too small to adequately develop baseline data. As a result of the baseline data some adjustments were made to the auditing tools. Additionally, the Nurse Managers had begun including corrective actions taken on the tools at the time of the audits. The process of developing CAPs was established and was implemented 6/30/13. At the time of the compliance review, the CAPs were in process, as well as the inter-rater reliability process. As the sample size increases, adjustments are made to the audit tools, CAPs are completed, and the inter-rater reliability process is finalized, improvements should be found in future results of the audit data. These items will be reviewed at the next compliance review.

<u>Assessment and Documentation of Individuals with Acute Changes in Status:</u>
Since the last compliance review the Facility had continued to expand the Integrated Morning Report (IMR) meeting to include more disciplines and had formalized a format for conducting and reporting issues reviewed and discussed during the meetings. The Monitoring Team attended the IMR s on 7/23/13 and 7/24/13. The meeting format was followed. The Infirmary Nurse and Hospital Liaison Nurses provided comprehensive reports on individuals they were following. The RN Case Manager Supervisor's took copious notes from the meeting and provided the information to RN Case Managers and other relevant nursing staff regarding the status of individuals reported on by all disciplines, and informed them of any needed nursing follow-up.

From the Monitoring Team's interviews with Nursing Administration, Management and Specialty Nurses, as well as from documents reviewed, the IMR appeared to have enhanced the collaboration and integration of services by the Nursing Department. The Monitoring Team was verbally provided with numerous examples of integration and collaboration, along with supporting documentation that demonstrated the integration of services between DSSLC

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		disciplines and IDTs as well as with outside facilities. For example: • Individual #553: In 2011, Individual #553 was hospitalized six times. Four of those admissions were for Urinary Tract Infections (UTIs) and sepsis. During this time period, she experienced 25 seizure episodes. It was thought by the team and her primary care provider that the high incidences if seizure activity were directly related to the high incidences of UTIs. Individual #553's primary provider ordered a urology consult. The diagnostic testing included a renal ultrasound, in which renal calculi were found. Consequently, interventions were put in place by the team to reduce/eliminate the incidences of urinary infections. The primary care provider ordered UTI Stat twice a day to minimized risk of infection. The dietitian evaluated intake to ensure that she received optimal amount of hydration. The nursing staff increased monitoring for signs and symptoms of infections. The Infection Control Preventionist and RN Case Manager provided education to staff on preventative measures to reduce the potential for urinary tract infections. The Direct Support Professional played a vital role in preventing infections by checking and changing Individual #553's briefs every two hours, reporting lack of voiding and/or other abnormal urine to the nursing staff, using appropriate perineal cleaning techniques, checking for signs/symptoms of temperature elevation, and reporting abnormal findings to the nursing staff. As result of these efforts, Individual #553 has not had a hospitalization or UTI since June of 2012. Reportedly, she is healthier and able to enjoy her favorite activities. It was positive for the Monitoring Team to find through interviews, observations, and documents reviewed that the Unit Nurse Managers had continued to enhance efforts toward improving the documentation and assessments of individuals with acute change in health status. These activities included but were not limited to: • Daily the Nurse Managers reviewed the Injury Report Summary that listed all injuries that occurred on the previous day. The assigned primary care nurses and/or charge nurses were responsible for assessing individuals with injuries within 30 minutes of notification and completed all required documentation. • Daily the Nurse Managers reviewed the 24 Hour Nursing Reports and clinic lists for the previous day. They reviewed the documentation on the reports and clinic list to see if the primary care nurses had implemented Acute Care Plans when needed, and if the assessments were completed and documented according to the respective protocol card. • Daily the Nurse Managers reviewed the Infirmary census to see if individuals were admitted from their respective units or the hospital. • Daily the Nurse Managers makes rounds on their respective units. The charge nurses were also responsible for making rounds on each shift and for assisting the primary nurses as needed. • The Nurse Managers ensured that all nursing staff keep the protocol card with them at all times for ready reference in providing care and documentation.	

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		• Weekly the Nurse Manager attended their respective units' Incident Management Review Team meetings. The attendees reviewed the 24 Hour Nursing Reports, clinic lists, restraint reports, injury reports, and appointment schedules. The team followed up on any outstanding issues with their respective supervisors, RN Case Managers, unit nurses, and other relevant disciplines. • Weekly the Nurse Managers ensured the charge nurses and/or primary care nurses checked the glucometers. • Monthly the Nurse Managers reviewed the emergency equipment checklists for their respective units to ensure that the charge nurses completed a monthly audit to ensure all emergency equipment was present, in good working order and the emergency equipment checklist were completed as required. It was the responsibility of the units' primary care nurses to check the emergency equipment each shift and complete the checklists. • Monthly the Nurse Managers notified the respective units' nursing staff of the competency of the month training dates and times after receiving the Nurse Educators' calendar for the month. Since the training was provided during the workday, nurses' schedules had to be re-arranged to accommodate the training. • Weekly the Nurse Managers completed assigned Medication Administration Observation on their respective units. The outcomes of the observations were discussed at the 1:00 p.m. nurses meetings. Daily or as needed, they reviewed and investigated medication variances that occurred on their respective units. Afterwards, they reviewed and discussed the medication variances with the nurses who committed the variances, as well as provided education on how to prevent future variances. If needed the nurses were referred to the Nurse Educators for further re-training. Monthly they completed a Medication Variance Report for their respective units and provided the reports for further review, discussion and disposition at the Pre-Medication Variance Committee meetings. Additionally, they reinforced the importance of the use of PNMPs and the need to provided individuals' with privacy during medication administration. No doubt the enhanced efforts put forth by the Nurse Managers have contributed to the Monitoring Team's positive findings identified throughout this Provision's report, as well as in reports for other Provisions. The Monitoring Team reviewed the most recently reported monitoring data for documentation for the four quarters of 2012, reported in the QA/QI Council Report on 12/12/12. The Documentation monitoring data showed an overall score of 85.1% compliance. The Nursing Department had started including documentation in the Protocol Card Audits. The Monitoring Team reviewed a sample selected from the Facility's At Risk List for individuals identified at high risk health conditions and from each unit for 25 unified/active	

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		records for Individuals: #365, #279, #392, #242, #123, #331, #791, #783, #553, #228, #239, #379, #566, #34, #95, #694, #171, #605, #531, #665, #244, #704, #735, #463, and #304 selected across Units/Infirmary, who were rated at high and/or medium risk for a variety of health conditions, and identified that 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 show improvement. The improvements may be attributable to several action steps taken, which included: The Physical Assessment Class completed by all RN Case Managers and RNs and the Documentation Class completed by RNs and LVNs, and implementation of 23 nursing protocols with increased monitoring by the Unit/Infirmary Nurse Managers. <u>Areas that showed continued improvement:</u> • There was consistent use of the SOAP format for documentation. • The nursing entries were consistently timed. • The nursing staff consistently notified the medical providers' promptly when there were significant acute changes in individuals' physical and/or mental health status. • There was significant improvement in consistently following the 23 nursing protocols, as indicated for specific problems. • Individuals placed on 24 and/or 48 hour Nurse Watch Monitoring were more consistently followed through to resolution. • The follow-up documentation of assessments on individuals with acute change in status more consistently stated what would be followed up on, but did not consistently state the frequency of the follow-up activities. • Individuals' response to per necessary (PRN) medications were more consistently documented on the back of the Medication Administration Record (MAR) and/or in the Integrated Progress Notes. There was significant improvement in the assessment and documentation of the effectiveness of the PRN medications. The Pain Protocol was more consistently followed for assessment of pain and follow-up. Individuals' physical/behavioral manifestations of pain were documented. • Individuals' level of comfort or discomfort and mental status were more consistently included in the assessments completed related to the illnesses or injuries. • The Pre and Post Hospital and Emergency Room Visit Records were more consistently completed according to the Nursing Protocol: Hospitalizations, Transfers, and Discharges. • Documentation in the Integrated Progress Notes was beginning to show more collaboration/integration with other disciplines. • There was significant improvement in the assessment and documentation of injuries related to individuals 'maladaptive behaviors but there was a continued need to report such injuries to the behavioral staff. <u>Areas that need continued improvement:</u>	

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		• The resolution notes for nursing care provided to individuals' with acute changes in status issues were not consistently documented when their problems were resolved. Neither was there consistent documentation as to whether the acute changes of status were resolved or the effectiveness of the treatments/interventions provided. • When errors were made in documentation they were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed. • Late entries were not consistently documented correctly. • There was a continued lack of consistent documentation in the Integrated Progress Notes when IHCPs and/or Acute Care Plans were initiated and whether the direct care professionals were trained on the plans. • 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. • The legibility of the nurses' handwriting had somewhat improved but the signatures and titles for some nurses continued to be illegible. Although improvements were noted through interviews, record reviews, and observations, the Nursing Department needs to ensure that the positive practices are maintained and strengthened to meet compliance with this requirement. For the next six months the Nursing Department should consider focusing on the areas identified that need continuous improvement. <u>Hospital Liaison Nurses' Activities:</u> As was found in previous compliance reviews, the Hospital Liaison Nurses continued to perform the following activities: • The Hospital Liaison Nurses continued to have credentials with Denton Regional Medical Center Hospital that allowed them to have full access remotely and in-hospital to individuals' hospital records, communicate directly with individuals' primary and charge nurse, as well as the ability to discuss individuals' diagnoses and concerns with the admitting physicians and any consult physicians. This continued to positively impact the overall care of individuals by having and sharing accurate and timely health information with the primary care providers and IDTs. The accurate and up to date information available prior to the individuals' discharge enabled the IDTs 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,	

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		positioning schedules, and diets were accurately followed while hospitalized. • Hospital Liaison Nurses made daily hospital rounds (Monday through Friday) to individuals hospitalized. Designated nurses maintained contact with the hospitals on weekends and holidays. • The Hospital Liaison Nurses thoroughly assessed the health status of each individual visited by direct observations, interviews with relevant hospital personnel, and review of medical records. The results of the visits were documented on the required standardized Hospital Liaison Report Forms, which were filed in the Integrated Progress Notes Section in chronological order. All items on the report forms were consistently addressed along with detailed narratives of additional pertinent information. 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. • The Hospital Liaison Nurses attended the daily IMR meetings and reported on the status of hospitalized individuals. • The Hospital Liaison Nurses 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. • Hospital Liaison Nurses attended Pre and/or Post Hospital Discharge ISPA meeting to assist IDTs to plan for the individual's return home with all needed supports and services identified as a result of the hospitalization. In addition, the Hospital Liaison Nurses attended and participated in Physical and Nutritional Management Team (PNMT), 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, the teams 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 continued to result in a more integrated approach for care of the individuals served. The Monitoring Team validated the above activities through interviews with Hospital Liaison Nurses, attendance at the IMRs on 7/23/13 and 7/24/13, and review of daily Hospital Liaison Reports for recent and/or currently hospitalized Individuals #86, #148, #576, #170, #279, #423, #760, #750, #654, #769, #198, and #551. <u>Additional Hospital Liaison Nurses' Activities:</u> • Quality Assurance Activities: The Hospital Liaison Nurses conduct QA audits using the Urgent Care/ER/Hospitalization monitoring tool on records assigned by the QA	

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		Department, as described above in the Nursing Department's QA Process. • Integration of Services: During the interview with the Hospital Liaison Nurses, they provided examples of activities that demonstrated further integration efforts within DSSLC, as well as with hospitals and long term acute care facilities. Examples: o Hospital liaison Nurses worked with the Campus Coordinators and ITH to improve relationships and care of individuals during hospitalization. They worked with relevant DSSLC staff to revise the General Guidelines for DSSLC Staff Providing Care at a Hospital; then they worked with Campus Coordinators and DSSLC staff to implement the guidelines to improve care during hospitalization. They continued collaborating with designated staff routinely caring for these individuals to encourage a team approach in care and continuity of responsibilities. The Hospital Liaison Nurse identified individuals hospitalized at ITH that were not receiving oral suction toothbrushing. This was addressed with ITH staff, who stated this would require a physician' order for their respiratory therapist to carry out. She contacted the physician and requested suction toothbrushing orders for all individuals with G-tubes. The physician agreed and wrote the orders. The Hospital Liaison Nurse also collaborated with the ITH Director of Nursing on an addendum to admission paperwork to add suction toothbrushing to admission orders for all appropriate DSSLC individuals. In addition, she collaborated with the PNMT Nurse regarding the interactions with ITH. On 7/12/13 the Hospital Nurse Liaison Nurses and the Compliance Nurse met with ITH's Director of Nursing and the Chief Compliance Officer and discussed concerns to improve communication and individuals' outcomes for hospitalized individuals. They discussed the need for more education for ITH staff by way of providing information on developmental disabilities, as well as including PBSPs for individuals who require such plans • When adverse drug reactions were identified on hospitalized individuals, the Hospital Liaison Nurses notified the DSSLC Pharmacy Director. This improved communication ensured records were updated to show any new medication allergies to prevent future exposure to a particular medication. They also report this information to the Incident Management Review Team (IMRT) and at the IMR to ensure health care providers, unit directors, and other disciplines were aware of this information. They also documented supporting information of adverse drug reactions to a particular medication in individuals' permanent records and provided additional copies of this documentation to the Pharmacy. For example: While Individual #602 was hospitalized for fever, on 7/19/13 he was observed with a rash following Vancomycin administration. This information was reported to the pharmacy. • In the past year DSSLC had several issues with leaking G-tubes. The Hospital Liaison	

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		Nurse arranged informal in-service training with DRMC ENDO Lab Nurse, of which several habilitation and PNMT staff attended. The training included several aspects of G-tube management to prevent leaking. This information was provided to relevant IDT members to increase awareness of managing/monitoring the external bolsters to prevent movement and leaking. This demonstrated her responsibility to provide coordination/integration of services with other disciplines and IDTs. • The Hospital Nurse Liaison Nurses communicated/collaborated daily with DSSLC Infection Control Preventionist and PNMT Nurse regarding aspiration pneumonias and infections when they are diagnosed on hospitalized individuals to ensure they are provided with accurate documentation. They informed the Infection Control Preventionist of positive cultures to ensure that they were accurately trended and followed-upon with infection control measures. In addition, they worked closely with the hospital and Infection Control Preventionist to ensure individuals' immunization records for influenza and pneumococcal vaccinations were updated whenever these particular vaccines were administered in the hospital, as well as updating the hospital records on vaccination dates so individuals do not receive duplicate vaccinations. If this requirement were a standalone provision, it would be considered in substantial compliance. <u>Diabetic Nurse Educator Activities:</u> Since the last compliance review, a new Diabetic Nurse Educator was appointed on June 1, 2013. The former Diabetic Nurse Educator assumed the position as RN Case Manager Supervisor but continued to mentor, train, and provides consultation to the newly appointed Diabetic Nurse Educator. As a result, the Monitoring Team's interview with the Diabetic Nurse Educator, review of diabetic tracking, analysis, and trend data, and review of individuals' records diagnosed with diabetes, found no gaps or lapses in diabetic services with the change in position. In addition, the information demonstrated significant integration of services and supports with other relevant disciplines and the IDTs in the management of diabetes, as reported below. With mentoring from the former Diabetic Nurse Educator the new Diabetic Educator was actively assuming her new responsibilities. The Monitoring Team was provided a copy of her job description detailing responsibilities and duties as related to meeting Facility priorities and specific responsibilities related to specific Section M Provisions. Responsibilities included, but were not limited to: • Monitors blood sugar data, medication administration records (MARs), dietary records and IDT notes at least weekly and after each incidence of hypoglycemia or hyperglycemia on individuals at highest risk. Insulin dosages (sliding scale) were verified for accuracy by referencing physician's orders during rounds in the homes. • In the event of episodes of hypoglycemia or hyperglycemia, the IDT notes are reviewed to assure that protocol for management and notification to the primary care provider had	

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		been followed. If not, the Diabetic Nurse Educator provides immediate follow-up with notification of nursing management and instruction/counseling for the nurse involved. • After review of all information related to diabetic management, findings are communicated to all members of the IDT for review and recommendation. • Monthly, cumulative data related to insulin adjustment and resultant trending is graphed for the individual whose medical regimen includes the administration of insulin. Facility-wide trends are cumulated, which demonstrate the efficacy of diabetic management across the campus. • Emergency Diabetic Supply Kits are available for use in all common areas across campus. The Diabetic Nurse Educator monitors the use of these kits, through immediate replacement and follow-up after an incident. The incident is investigated to assure that established protocols for management of hypoglycemia are adhered to. • Glucometer Controls are performed weekly, using two levels of control solution across campus to assure quality glucose monitoring. Primary or charge nurses are responsible for the completion of the quality controls. Nurse Managers verify the completion weekly and the Diabetic Nurse Educator provides oversight while making round in the homes. • The Diabetic Nurse Educator is regarded as an active participant in the planning, implementation, and evaluation of care for individuals with diabetes across the campus. This role has evolved into one of not only education, but also counseling and coordination of services, on and off campus. Through the Monitoring Team's interview and review of documents, the new Diabetic Nurse Educator summarized the accomplishments she had made to date: • All blood sugar logs for individuals' diagnosed with insulin-dependent diabetes mellitus have been updated for the months of April and May 2013 in the shared database along with their trending graphs. • An updated list of individuals followed with a diagnosis of diabetes who were on a medication was included in the shared drive. • Contact was made with each nursing unit and numerous in-services were provided on "The Myths of Diabetes". This included the importance of water intake in the summer months and how weather will not drop blood sugars. • A desensitization program was suggested for one individual who has not allowed blood sugar testing. • Worked closely with the dietitians to offer a solution to the meal choices for individuals with the diagnosis of diabetes, possibly by limiting carbohydrates and starches. This was still in the planning stages. • Attended endocrine appointment with individuals to establish rapport with the endocrinologist and their staff. • Maintained the database for trending blood sugar levels for all individuals' daily, monthly, quarterly and longitudinally. Analyzed and trended data for each individual, as well as	

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		campus-wide. This information was provided to the individuals' primary care provider and to individuals' endocrinologist at their appointments. The information was also presented to the PNMC. These reports reflect individuals' current treatment regimen and were utilized to establish recommendations for changes in treatment. • Worked collaboratively with all levels of nursing staff and other disciplines and staff working with individuals with diabetes. • Kept the Nursing Administration Team/PNMC updated on educational opportunities for staff and individuals. • Updated plans and will to continue to update existing guidelines/processes for diabetic education as changes are indicated. • Future goals: o Revamp the meal choices for individuals with diabetes to better control the highs and lows of their blood sugars throughout the day. o Establish an Endocrine Clinic on campus to enable the Facility to better care for individuals with diagnoses of diabetes. As of July 2013, the Facility had 60 individuals diagnosed with diabetes. With a population this great the need for a Diabetic Nurse Educator is vital in the management, coordination, collaboration, and integration of diabetic care both within the Facility and with outside providers. The tracking and analyses of hypoglycemia and hyperglycemia data was validated through review of June 2013 Diabetic Management Summaries for Individuals #367, #335, #276, #517, #753, #35, #89, #19, #401, #331, #402, #490, #560, #90, and #395. The campus-wide Diabetic Management Summary for April and May 2013, the Facility reported: • Improvement in the incidents of low blood sugar (<70) continued. Although the Monitoring Team found in the last compliance review that data had been available and that the data reviewed by the Monitoring Team had indicated a progressive decrease in both hypoglycemia and hyperglycemia, and although the Facility reported the data are recorded monthly, the Monitoring Team received data only for April and May 2013. Recorded as mean values for comparison and review: o April: 4.67 mean o May: 4.60 mean • Significant and continued improvement in the incidence of high blood sugar (>300). o April: 14.00 o May: 11.53 (18% decrease) A review of Integrated Progress Notes for Individuals #35, #89, and #19 showed the Diabetic Nurse Educator demonstrated collaboration with the home nurses in assessing and managing high and/or low blood sugar levels. Individual #89's Integrated Progress Notes demonstrated	

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		the collaboration in the assessment and management with an unstageable ulcer of left heel to better control blood sugar levels to promote healing. If this requirement were a standalone Provision, it would be considered in substantial compliance. <u>Skin Integrity Nurse Activities:</u> Since the last compliance review, a new Skin Integrity Nurse was appointed as of June 1, 2013. The former Skin Integrity Nurse acquired Nurse Practitioner licensure and continued to provide services through the Medical Department and continued to mentor, train, and provide consultation to the newly appointed Skin Integrity Nurse. The Monitoring Team was provided a copy of the Skin Integrity Nurse's job description detailing responsibilities and duties relating to meeting Facility priorities and specific responsibilities related to specific Section M Provisions. As reported in the Facility Self-Assessment, and verified through documentation, the Skin Integrity Nurse achieved certification in Skin and Wound Management on 6/6/13, though the Wound Care Education Institute, Lake Geneva, Wisconsin. A summary of key Skin Integrity Nurse Responsibilities included: • Assessments and documentation of individuals identified with skin integrity issues by Primary Care Providers (PCPs), nurses, and other team members. • Performs collaborative assessments on individuals, as indicated. • Attends daily medical rounds to keep informed of individuals' changes in status. • Uses critical thinking skills to identify cause of skin integrity issues and formulate effective strategies. • Collaborates with IDT and PNMT as needed to address position needs, as well as other needs. • Attends IDT meetings, as needed. • Collaborates with other specialty nurses as needed to integrate hospital information, training, and infectious issues. The Skin Integrity Nurse reported that progress had been made in continuity of care and improving the safety of individuals' served. Issues were addressed in a timely manner and there was collaboration between team members, as well as with outside facilities to improve care. As was found at the last compliance review, the newly appointed Skin Integrity Nurse continued to maintain the positive practices identified by consistently following, tracking, analyzing, and trending skin integrity issues and decubitus ulcers/pressure ulcers data monthly and longitudinally. The Facility no longer conducts a separate Skin Integrity Committee. The skin integrity data were reported along with supporting documentation	

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monthly at PNMC meetings to keep the IDTs informed of the status of individuals' skin integrity issues, as well as the incidences of skin integrity and pressure ulcers campus-wide. The first skin integrity data was presented to the PNMC on 6/14/13, as verified in the minutes. In addition, as a clinical key indicator pressure data were provided monthly to the QA/QI Council meetings for review and disposition.

The Monitoring Team attended the weekly PNMC Committee on 7/25/13, where the status of the Skin Integrity Nurse's activities and pressure ulcer trend data were presented, along with CAPs initiated and completed in July 2013 to reduce the incidents of pressure ulcers acquired at ITH, as discussed below in the report.

The Monitoring Team was presented three charts of summarized of skin integrity data for July 2012 through June 2013. The summary data charts described the number of individuals per month, where they were acquired, type of pressure ulcer, and incidence rates, as well as a detailed chart that reported monthly pressure ulcers by unit, individual, date, stage, location, where acquired, treatment, and status of healing. One chart also described other types of wounds. Since the last compliance review, the method for presenting skin integrity data showed improvement by representing data in chart format as opposed to a narrative listing that was difficult to interpret, as demonstrated in the charts below for the Skin Integrity Report for June 2013 that included monthly trend reports, incident rates, list of newly diagnosed pressure ulcers, and follow-up from previous month:

Skin Integrity Report for June 2013

Pressure Ulcers	7/12	8/12	9/12	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
Number of Individuals	4	2	1	0	0	1	2	2	3	4	5	5
Apartment acquired	3	1	1	0	0	1	2	1	0	2	3	1
Infirmary Acquired	0	0	0	0	0	0	0	0	1	0	0	0
Hospital Acquired	3	1	0	0	0	0	0	1	5	4	2	9
Stage I	0	0	0	0	0	0	0	0	0	0	0	0
Stage II	3	1	1	0	0	1	2	0	0	1	3	4
Stage III	2	0	0	0	0	0	0	0	4	3	1	3
Stage IV	0	1	0	0	0	0	0	0	0	0	1	0
Unstageable	0	0	0	0	0	0	0	2	0	2	0	0
Deep Tissue Wounds	1	0	0	0	0	0	0	0	2	0	0	3
Total Wounds	6	2	1	0	0	1	2	2	6	6	5	10

Pressure ulcers trend reported as of 7/10/13 will be represented in August 2013.

Of the total 41 pressure ulcers reported July 2012 through June 2012, 25 (60.97%) were

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		hospital acquired, 15 (36.58%) were apartment (facility) acquired, and 1 (2.43%) was Infirmary (facility) acquired. The significant increase in the incidences of pressure ulcers occurring in March, April, May, and June 2013, were hospital acquired, primarily at ITH, and were caused by poor positioning and the wrong type of mattresses. According to interviews with the Hospital Liaison Nurse, Skin Integrity Nurse, PNMP Nurse, and Infection Control Preventionist, they collaborated with and integrated interventions with ITH staff to reduce the incidences of pressure ulcers occurring at ITH. There was also an increase in the incidences of pressure ulcers reported that occurred in the apartments. In addition, on 6/5/13, the Occupational Therapist (OTR) and Physical Therapist (PT) provided in-service training to CNE, RN Case Manager Supervisor, and RN Case Managers on Bed Supports, Mattress Options, and Pressure Ulcers. Refer to Hospital Liaison Nurses Activities above regarding reports of collaboration with ITH. In addition to the integrated findings reported in the Hospital Liaison Nurses' Activities, the Monitoring Team's review of Individual #86's Integrated Progress Notes on 7/1/13 found there was further collaboration and integration of services between ITH and the PNMT OTR and PNMT RN. The notes indicated that they visited Individual #86 at ITH secondary to the development of a pressure wound on her right hip. The wound was a stage II pressure ulcer per the ITH RN. At the time of the visit, Individual #86 was found in bed in a slight left semi side-lying position but the right hip was not off loaded. There was no staff in the room with her and no observation notes were found for the day. The wound was examined by OTR and PNMT RN and was found open and the approximate size of a quarter. The wound appeared to be pressure related on the ischial tuberosity. Reportedly, she had minimal body fat and her position of comfort was on her right side. She had a therapeutic foam mattress. The PNMT OTR discussed the use of a low air loss mattress with the ITH Hospital Liaison, who agreed to address it with the ITH Wound Care Nurse. The bed appeared elevated over 30 degrees as required and her head was not at the top of the bed. Individual #86 was repositioned up in bed and repositioned on left semi side-lying with pillows under her back to off load the right hip. Oxygen was provided at two liters via nasal cannula, however; the cannula was not in her nose and appeared dirty. It was placed in her nose and the ITH Hospital Liaison was notified of the issue with the cannula. Individual # 86's oral hygiene appeared poor as evidenced by a thick film over her teeth. No suction toothbrush was found in her room, only pink toothettes for oral care. This was discussed with the ITH Hospital Liaison. The DSSLC sitter indicated that they used the pink toothettes for oral care; however, her teeth were to be brushed with a suction toothbrush due to G-tube feedings. Her G-tube site had slight redness. The feeding was not going (on bolus). Her stomach was found distended and firm to touch. This was discussed with the ITH Hospital Liaison. The PNMP OTR made the following recommendations: Request a low air loss mattress; evaluate decreasing Bantol (banana	

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		flakes); implement position schedule to decrease pressure on the right hip, the ITH PT/OT to assess wheelchair as an alternative position option depending on wound; and suction toothbrushing for oral care. A review of the DSSLC Hospital Liaison notes, 7/2/13 through 7/15/13, found that ITH had followed through with the above recommendations. This example demonstrates the vital need for DSSLC staff to collaborate and coordinate services with outside facilities as well as within the Facility. The Monitoring Team interviewed the Skin Integrity Nurse and reviewed six individuals' records that had active skin integrity and/or pressure ulcer issues. The results of the Skin Integrity Nurse's collaborative and integrated activities implemented in the management of pressure ulcers/wounds are summarized in the examples below: • Individual #393: The Skin Integrity Nurse was notified of Individual #393's sacral wound on 5/2/13 and completed an assessment of the wound. The Skin Integrity Nurse found the sacral wound had healed,, but a pressure wound was found on the coccyx. The Skin Integrity Nurse contacted the Habilitation staff regarding the possibility that the wound was due to wheelchair pressure and current positioning schedule. Consequently, habilitation staff changed Individual #393's positioning schedule. The DSP staff were instructed on the changed positioning plan and the importance of strictly adhering to the schedule was reinforced, as well as to inform the nurse if the wound dressing became soiled or dislodged. The dietitian was contacted and added a protein supplement. An appointment with the Wound Care Specialist was scheduled. By 7/23/13, the wound showed great improvement going from 0.1 cm x 0.1 cm x 0.1 x 0.1 cm 5/2/13 to less than 0.1 cm, pin hole size. • Individual #734: On 4/23/13, the RN Case Manager notified the Skin Integrity Nurse of Individuals #734's slow healing ulcer on the left shin and requested she assess the ulcer and offer assistance in managing the ulcer. Individual #734 had vascular disease with reoccurring weeping ulcers. The Skin Integrity Nurse elicited a wound management history from the RN Case Manager, Clinic Nurse, Primary Nurse, and DSP staff. She was told when the skin on his legs begin to flake and gets pulled off it caused the skin to open, and then it was hard to heal the wounds. The Skin Integrity Nurses discussed the possible use of shin guards for protection with the RN Case Manager but they thought the shin guards would do more harm than good. The use of TED hose was tried in the past as a preventative measure but he would not leave them on. The Skin Integrity Nurse discussed the need for compression through the use of ACE wraps with the RN Case Manager, Primary Nurse, and PCP. Subsequently, they were ordered and as a result he left them on. The Primary Nurse was instructed to check the circulation in the legs every four hours and to monitor for wrinkles, and for other pressure areas. The DSP staff were instructed to notify nursing if his wraps became wrinkled, came off, or they noticed indentions in the skin or he appeared to show any discomfort. The DSP staff and RN Case Manager reported to the Skin Integrity Nurse thatwith the ACE wraps he tolerated activities that involved touching the lower legs, which before he would not allow. The ACE wraps used	

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		for compression were effective. The legs had not had any moist wounds since the ACE wraps were used. • Individual #750: The Skin Integrity Nurse received a report from Individual #750's RN Case Manager that she had skin breakdown on the abdomen related to drainage from an old J-tube site. The tube had been removed and allowed to close but the opening continued to ooze drainage. The PCP was notified and it was decided to put an ostomy bag over the J-tube site to catch the drainage and protect the skin. The Skin Integrity Nurse provided teaching to the Primary Nurse on proper application of the ostomy bag. The DSP staff were instructed to notify the nurse if the bag became dislodged. A gastrointestinal consult was sent requesting closing the tube site surgically. On 6/15/13, Individual #750 was admitted to the hospital with aspiration pneumonia. The Skin Integrity Nurse went to the ITH and assessed Individual #750 with the ITH Skin Integrity Nurse. The ITH Hospital Liaison suggested stopping the tube feeding to decrease drainage in order for the skin to heal and notified the physician. When the Skin Integrity Nurse and PNMT RN visited Individual #750 on 7/10/13, the feeding was on hold and total parenteral nutrition (TNP) was being administered. The condition of the skin on the abdomen was founded unchanged. The Skin Integrity Nurse, PNMT RN and OT reassessed Individual #750's skin on 7/16/13, which showed some improvement. The Skin Integrity Nurse assessed the skin again on 7/23/13, and it continued to show improvement. The ITH Hospital Liaison reported they were waiting for the pneumonia to resolve, and then they would get a surgical consult for closure of the J-tube stoma site. The Skin Integrity Nurse continued to keep in contact with the ITH Wound Care Nurse regarding Individual #750's health status. Because of the investment of effort the Facility disciplines reported they had put forth to work with hospitals, particularly ITH, to reduce the incidences of pressure ulcers, the Monitoring Team will review the incidences of hospital acquired pressure ulcers at the next compliance to see if there has been a reduction in occurrences. The Monitoring Team interviewed the Skin Integrity Nurse and reviewed the records for Individuals #583, #392, and #242 who had active skin integrity and/or pressure ulcers, and found the same level of collaboration and integration of services with relevant DSSLC disciplines/staff and outside facilities staff, as was found in the above examples. It was positive to find that entries in the Integrated Progress Notes (IPNs) were consistently documented in the Subjective, Objective, Assessment/Analysis, and Plan (SOAP) format, with the plan (P) including follow-up actions as opposed to simply stating "continue to monitor." However, several issues were identified regarding documentation in the Integrated Progress Notes and the content of health care plans. For example: • Many of the notes written in the IPNs by the Skin Integrity Nurse, other nurses and disciplines appeared to be written on a separate progress sheets, along with frequent gaps	

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		in daily or required frequency for assessments and documentation according to individuals' plans of care. Often found in the Integrated Progress Notes were blank lines between entries, as well as blanks left on the remainder of the sheets. All entries should be written chronologically, by all nursing staff and other relevant disciplines, into the progress notes without leaving blank spaces on the sheets. There should be no gaps in entries when daily assessments and documentation are required for individuals according to their plans of care. In addition, as found in previous reviews, pertinent communication regarding the collaboration and integration of individuals' care between disciplines continued to be found in email communications. All essential communication should be documented in individuals' active/unified records because email communication is not an official part of individuals' active/unified records. This has the potential for pertinent information to be missed and/or lost over time, which can interfere with continuity of care. Although the Integrated Progress Notes reviewed showed wound assessments were consistently completed and documented, including their size, description, evidence of infection, pain, and stage of healing, the Nursing Department should consider using one of the nationally accepted methods for clinical monitoring of pressure ulcers to trend pressure ulcer stages of healing over time, such as the National Pressure Ulcer Advisory Panel's Pressure Ulcer Healing (PUSH) chart. This method for monitoring the stages of pressure ulcer healing is being used in some of the State Supported Living Centers. To date the state office had not developed a protocol for skin integrity issues, which might be helpful to the nursing staff when assessing and documenting such issues. Refer to Provision M.3 regarding Acute Care Plans and management of skin integrity issues. If this requirement were a standalone Provision, it would be considered close to achieving substantial compliance. <u>Infection Control Preventionist Activities:</u> Since the last review, the Infection Control Preventionist had continued to maintain the positive practices identified in the last compliance review and to make 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 and changes made since the last compliance review: • <u>New and/or Changes to Infection Control Policies, Procedures, and/or other documents addressing Infection Control:</u> o Infection Prevention and Control Policy: ▪ Under Immunization this statement was added, "Employees who will decline to receive the influenza vaccination will be encouraged to complete the Declination of Influenza Vaccination Form."	

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		▪ Under Client Health Services a whole paragraph was added regarding Tuberculosis Screening. The significant change included, "Tuberculin-positive individuals will be evaluated annually for signs or symptoms compatible with active tuberculosis (e.g., persistent cough, anorexia, weight loss, night sweated, etc.). Chest radiography will be performed only when clinically indicated." o MDRO (multi-drug resistant organisms): Under Infirmary Care a paragraph was added, "In many instances an individual who had been shown to have eradication of MDRO can often be shown to be recolonized weeks, months, or a year later per CDC (Centers of Disease and Control) Guidelines of 2006, considering patient to be "permanently colonized" in regards to readmission to the Infirmary." o Hand Hygiene Policy was a new policy. The policy was reviewed by the Monitoring Team and it was found to be consistent with currently accepted standards of practice, as recommended by CDC. • <u>Infection Control Training Activities by the Infection Control Preventionist:</u> o Provided training on 4/15/13 to all Nurse Managers on new and/or changes to the Infection Control, Hand Hygiene and MDRO Policies. o Provided training on Clostridium difficile Protocol and Clinical Practice Guidelines for Clostridium difficile to Nurse Managers, RN Case Managers, and primary care providers as a refresher. o Provided Infection Control training on Infection Control to all new employees at New Employee Orientation and annual refresher training to incumbent staff. <u>Infection Control Committee Meetings:</u> The Facility no longer had a separate Infection Control Committee. The Infection Control Preventionist presented reports of infection control data on a quarterly basis and as needed, at the PNMC meetings, for further review and disposition. The Infection Control Preventionist presented new cases of aspiration pneumonia weekly at IMRT meetings for review and disposition. The Infection Control Preventionist presented clinical indicator "All Infections" monthly at the QA/QI Council meetings. <u>List of Infection Control Monitoring Tools:</u> o AVATAR Pneumonia/Aspiration Pneumonia Tracking o AVATAR Immunization Tracking o AVATAR Infection Tracking o Communicable Disease Database o Individual Immunization Database o Employee Immunization Database o Handwashing Skill Assessment Tool o Home/Apartment Surveillance Report o Antibiograms	

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		o Hygiena ATP Monitoring Tool • Handwashing Surveillance monitoring was completed monthly. At least 50 employees, December 2012 through May 2013, were monitored for proper technique in handwashing and to ensure all healthcare workers were adhering to the new Hand Hygiene policy, which included no acrylic/artificial fingernails if they have direct contact with individuals. 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. Handwashing surveillance was performed in the homes/apartments by the Infection Control Preventionist and other nurses. The data were tracked, analyzed, trended, and corrective actions were taken as needed, and reported quarterly to the PNMC for further review and disposition. This was validated through the Monitoring Team's review of supporting documentation provided in the document request and PMNC minutes related to the Infection Control Preventionist's quarterly reports January 2013 and April 2013, submitted to PNMC. The audits continued to find some female employees wearing acrylic or artificial fingernails. • Home/Apartment Surveillances were completed at least twice a week or as needed if there was an infection issue reported in a particular home/apartment. The Infection Control Preventionist completed surveillances using Hygiena ATP Monitoring Swabs to monitor the cleanliness of environmental surfaces. Data were tracked, analyzed, trended, and corrective actions taken as needed, and reported quarterly to the PNMC for further review and disposition. This was validated through the Monitoring Team's review of supporting documentation provided in the document request and PMNC minutes related to the Infection Control Preventionist's quarterly reports January 2013 and April 2013, submitted to PNMC. • The Monitoring Team's review of monthly Surveillance Reports, October 2012 through May 2013, showed that when confirmed cases of infectious and/or communicable diseases/condition were reported the Infection Control Preventionist completed and documented the investigations, implemented corrective actions, followed-up and reported on corrective actions taken, and reported the outcome resulting from the corrective actions. Examples of such actions taken for confirmed cases of infectious and/or communicable diseases/condition included: o Confirmed cases of head and pubic lice reported in 505C in October and November 2012. o Confirmed cases of conjunctivitis reported in 506C in December 2012. o Confirmed case of campylobacter reported in 512B in March 2013. o Confirmed case of Clostridium difficile (C-diff) reported in 512D in March 2012. o Confirmed case of Methicillin-resistant Staphylococcus aureus (MRSA) reported in 527D on April 2013. o Improper techniques for irrigating Foley catheters, which had the potential to cause cross contamination that may lead to a urinary tract infection was reported	

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		in May 2013. • The Monitoring Team's review of the Incidence of Infection data for October 2012 through July 2013, as report in the 7/2/13 PNMC minutes showed data were tracked, analyzed, and trended by infection types, which were represented in bar and linear graph. There was no narrative included on the graph to indicate the actual number and type of monthly infections reported. This was contrary to the way data were previously reported and/or provided to the Monitoring Team for review, which included the number of infections by type, percentage of occurrence, and rates for each type of infection. Therefore, it was not possible to discern the actual number of infections by type for: All Infections, Aspiration Pneumonia, Respiratory (not pneumonia), Conjunctivitis, Multi-Drug Resistant Organisms (various types of infections not distinguished), and Skin and Soft Tissue. Each graph contained a detailed explanation of the reason for action, action taken, month/year, and results. Overall the graphs represent a downward trend in the incidences of infections. The Infection Control Preventionist collects the pneumonia data from the Facility and hospitals, and tracked, analyzed, and trended pneumonia/aspiration pneumonia data, and provided recommendations for corrective actions. The Infection Control Preventionist worked collaboratively with the PNMT RN, who completed the AVATAR Pneumonia/Aspiration Pneumonia Tracking forms. The data were entered into the AVATAR by the Infection Control Preventionist. This data were presented periodically as a separate report of the Aspiration Pneumonia Workgroup to the PNMC. Refer to Sections L and O for more pneumonia/aspiration pneumonia information. • The Monitoring Team's review of Data Influenza Outbreak DSSLC January 2013 Report, showed that the influenza outbreaks data were tracked, analyzed, and trended by total number of individuals with confirmed cases of influenza, detailing the apartments affected, as well as identifying the individuals affected, type of influenza strain through swab 9 (influenza type A and B), and total number of individuals given Tamiflu prophylactically. Data Influenza Outbreak DSSLC January 2013 Report, further showed that the influenza outbreaks were tracked, analyzed, and trended by total number of employees with confirmed cases of influenza, by work areas, total number of employees who called in sick and/or were sent home with influenza-like symptoms, and their work areas. The reports also included a detailed report of steps taken at DSSLC during the influenza outbreak to prevent and/or minimize the spread of influenza. The report also included an analysis of follow-up actions taken, the need for further preventative measures, and the outcome resulting from the preventative infection control measures put in place to prevent spread of the infection. The preventative infection control measures put in place by the Infection Control Preventionist in collaboration with other relevant DSSLC staff were consistent with currently accepted standards of practice according to CDC. • There were no reports of infectious trends for employees beyond the influenza outbreak described above.	

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		• The Facility continued to contract with an Infectious Disease Doctor who provided consultation services on individuals' infections and education to clinical staff. • The Infection Control Preventionist Nurse continued to develop and publish monthly "Hands on Infection Control" Infection Prevention and Control Newsletters. The purpose of the newsletters was to provide all DSSLC staff with information and updates on contemporary infection control and prevention and control issues relevant to the workplace. • 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 provided to the medical providers and reported at the PNMC meetings. • The Infection Control Preventionist continued to provide training on Infection Control Measures, including Hand Hygiene and Standard Precautions, at New Employee Orientation and at annual refresher training. • According to CTD's Course Delinquency/Due List, 6/3/13, 25 employees were delinquent on annual refresher Infection Control Training. This was an increase since the last compliance review where 12 employees reported delinquent. It is essential that all employees remain current in their annual refresher Infection Control Training. • Currently the Facility was using the DSSLC Client Immunization Database. In June 2013, the Facility began using the AVATAR Immunization Tracking system for entering all immunization on new individuals admitted to the Facility. They were also entering individuals' Tuberculosis (TB) Skin Testing results into the AVATAR Immunization Tracking system. Immunization data were continuing to be entered into the new system for tracking. The tracking reports showed: o For 2013, there was a 100% compliance rate for individuals receiving annual tuberculosis (TB) skin testing. There were no individuals reported to have newly converted TB skin Tests. o For 2013, there was a 99.7% compliance rate for employees receiving annual TB skin testing. There were no employees reported with converted TB skin tests. o For 2012-2013 flu season, there was a 99.7% compliance rate for individuals receiving influenza vaccinations. o For 2012-2013 flu season, there was a 37% compliance rate for employees receiving influenza vaccinations. These vaccinations were made available to employees during the influenza vaccination year 2013-2014. Employees who refused the vaccines will be required to complete the Influenza Declination Form. o Year to date, 781 (47%) employees had received the complete series of Hepatitis B vaccinations. The majority of employees who received Hepatitis B vaccinations were healthcare workers who have direct contact with individuals. The Infection Control Preventionist and Clinic Nurse continued to offer the Hepatitis B vaccinations during New Employee Orientation, as well as to incumbent	

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		employees who were at risk (physicians, nurses, DSPs, respiratory staff, and other staff who provide direct care). • Through interview with the Infection Control Preventionist and review of documentation, a variety of methods were used to validate the reliability of infectious and communicable diseases reported.. These methods included, but were not limited to: Attendance at the Integrated Morning Meetings, daily Pharmacy Antibiotic Reports, 24 Hour Nursing Shift Logs, direct notification by the nursing staff, and review of individuals' lab reports for cultures and sensitivities. As was found in past reviews, the Nursing Department did not have a formalized written process for notifying the Infection Control Preventionist of infections and/or communicable diseases, although the documents reviewed indicated that the nursing staff were directly reporting such infections to the Infection Control Preventionist via phone calls, e-mail, and documentation in the Integrated Progress Notes. In order to ensure the Infection Control Preventionist Nurse has real-time reports of infections, the Nursing Department should consider developing and implementing a formalized written process for the nursing staff to notify the Infection Control Preventionist when infections and/or communicable diseases are diagnosed. • The Infection Control Preventionist reviewed and provided supporting documentation for examples of collaboration and integration with relevant DSSLC disciplines/staff, as well as outside facilities. For example: o Individual #552: In 2011, Individual #552 had seven episodes of urinary tract infections, in 2012 two episodes, and for 2013 to date, she has had no reported urinary tract. Extensive infection control measures were put in place in collaboration with her RN case Manager and IDT members to prevent reoccurrence of urinary tract infections. The Infection Control Preventionist provided information to the RN Case Managers and other team members for any results of urinary tract infections that were trending up and included recommendations on prevention. Reports on the HygeniaSure ATP monitoring swabs were also provided to make them aware of different contamination on environmental surfaces so that prompt cleaning and disinfection was done in identified areas. This report was also provided to the Housekeeping Department so that they could do more extensive cleaning/disinfection in areas identified. The Infection Control Preventionist provided in-service training to team members who have direct contact with individuals on the new Hand Hygiene Policy with emphasis on CDC recommendation regarding the proper length of natural fingernails and not allowing acrylic or artificial fingernails. She showed team members when ATP swabs were used on different types of fingernails how much contamination was left on the fingers with both acrylic and long fingernails even after washing their hands. In addition, the RN Case Manager conducted in-service training with the DSP taking care of Individual #552 on the importance of frequent handwashing, proper techniques for cleaning the female genitalia by wiping from front to back to prevent cross contamination, and frequent	

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		environmental cleaning and disinfection, as well as training on the Hands on Infection Control Newsletters on Hand Hygiene Saves Lives and Dehydration in the Elderly, developed and published by the Infection Control Preventionist. o Individual # 719: On 7/3/13, Individual #719 was diagnosed with an active case of Clostridium Difficile. There were no isolation beds available in the Infirmary and he was cared for in his apartment. As a result, the Infection Control Preventionist notified all members of the interdisciplinary team, including the RN Case Managers and the Housekeeping Department of the infection. She developed the Clostridium Difficile Protocol and Clinical Practice Guidelines for Clostridium Difficile and presented the information to the medical providers and other members of the interdisciplinary team, including RN Case Managers and the PNMC members. o Individual #587: On 7/15/13, Individual #587 was diagnosed with active MRSA on her G-tube stoma. She was an active individual who liked to move around. She particularly liked touching doorknobs. The Infection Control Preventionist contacted the contract Infectious Doctor regarding infection control measures since Individual #587 was not to be confined to isolation. He advised as long as the stoma was always covered to contain the organism and the staff practiced a lot of handwashing, she could be managed in her apartment. The Infection Control Preventionist designed a plan of action to manage care for the active MRSA, and then notified the Individual #587's Nurse Manager, RN Case Manager, Unit Director, Building Coordinator, and Housekeeping Director and provided them with the plan. o Individual #750: On 6/16/13, Individual #750 was admitted to the ITH with a diagnosis of aspiration pneumonia, hypokalemia, and hyponatremia. On 6/25/13, she developed pseudomonas in the sputum. As soon as the Hospital Liaison Nurse notified the Infection Control Preventionist of aspiration pneumonias and/or other infections, she notified members of the interdisciplinary team regarding the change in status both via email and at the IMRT meeting. Early notification of the team provided them with time to have meetings to discuss corrective action to be put in place. Once the Infection Control Preventionist was notified of the aspiration pneumonia, she began her investigation of all events before and leading up to the hospitalization. The data she gathered included: All triggers for aspiration like emesis, seizure activity, wrong body positioning/alignment, improper food/liquid/texture, and constipation, as well as other related problems that might have contributed to the aspiration like: Was the PNMP in place? Was a positioning schedule in place? Was there any suction toothbrushing being used, especially for individuals with multiple episodes of aspiration pneumonia. Any deviations in care were reported to the team and at IMRT meetings. The Infection Control Preventionist provided the Nurse Managers, RN Care Managers, Unit Director, Building Coordinator, and	

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		House keeping with infection control measures to use in educating their staff on the prevention of aspiration pneumonia. The Infection Control Preventionist collaborated with the PNMT RN. The PNMT RN completed the Pneumonia/Aspiration Pneumonia Tracking form and the Infection Control Preventionist entered the information into the AVATAR system. Since Individual #750 acquired pseudomonas at ITH the DSSLC Infection Control Preventionist also noticed a high trend in hospital acquired pseudomonas at ITH. She immediately contacted the ITH Infection Control Preventionist regarding the increased rate of pseudomonas there. She collaborated with the ITH Infection Control Preventionist and provided the corrective actions and prevention measures used at DSSLC for continuity of care at ITH. o Individual #551 was diagnosed with aspiration pneumonia and was currently in the hospital at the time of the compliance review. A review of documents found that the Infection Control Preventionist followed the same practices as identified above. Refer to Provision M.3 regarding Acute Care Plans and management of infections. It was readily apparent to the Monitoring Team through interview with the Infection Control Preventionist and from review of the voluminous supporting documentation provided for review in the pre-visit and onsite documents and review of individuals' records that the required aspects for managing the Infection Control Program were consistently, thoroughly, and substantively addressed. If this requirement were a standalone Provision, it would be considered in substantial compliance. <u>Availability of Pertinent Medical Records:</u> • Records were made available onsite without difficulty or delay. • It was positive to find that the Red Care Plan Notebooks had been revised to include the Integrated DSP Plans of Care. • Individuals' unified/active records contained Health Management Plans (HMPs) as well as the IHCPs. It was difficult to discern which of the two types of plans were followed. The HMPs were to be discontinued as IHCPs were developed and implemented. The Nursing Department should consider removing any of the HMPs that were no longer in use from the unified/active records. • The IPNs written by the Skin Integrity Nurse, other nurses and disciplines appeared to be written on a separate progress sheets, along with frequent gaps in daily or the required frequency for assessments and documentation according to individuals' plans of care. Often found in the Integrated Progress Notes were blank lines between entries, as well as blanks left on the remainder of the sheets. All entries should be written chronologically,	

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		by all nursing staff and other relevant disciplines, into the progress notes without leaving blank spaces on the sheets. There should be no gaps in entries when daily assessments and documentation are required for individuals according to their plans of care. • As found in previous reviews, pertinent communication regarding the collaboration and integration of individuals' care between disciplines continued to be found in email communications. All essential communication should be documented in individuals' active/unified records because email communication is not an official part of individuals' active/unified records. This has the potential for pertinent information to be missed and/or lost over time, which can interfere with continuity of care. <u>Mock Medical Emergency Drills and Emergency Response Activities:</u> Since the last compliance review, the Facility continued to maintain the positive practices previously identified. The Monitoring Team's review of supporting documentation and interview 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, as verified through the following: • The Facility continued to have all of the required emergency equipment, including 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. • A review of the completed Emergency Equipment and Automated External Defibrillators (AEDs) Walkthrough Checklists and the six months Summary Emergency Equipment and Automated External Defibrillators (AEDs) Walkthrough Checklists, October 2012 through May 2013, found that the emergency equipment and AEDs were checked per policy, and when problems were identified there was evidence that corrective action was taken. Utilizing the Nurse Managers' monitoring tool for checking emergency equipment and AEDs in identified location, October 2012 through May 2013, showed an overall average of 98% to 100% compliance rate of daily emergency equipment and AEDs checks per policy. • 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 and AEDs were located to ensure staff knew the location of the equipment. • 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. • The Security Director continued to schedule, track, analyze, and provide completed Mock	

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		Medical Emergency Drills Reports to the Quality Assurance Department. According to the QA/QI Report for the reporting period November 2012 through 2013, no CAPs were required. • A review of the Incident Management Review Team Meeting minutes for the October 2012 through June 2013, included reports of the completed Mock Medical Emergency Drills along with any deficiencies found and the accompanying corrective actions taken. • A review of the Mock Medical Emergency Drill data, November 2012 through May 2013 showed that completion of required and scheduled drills were completed with and overall average compliance score above 95% for the reporting period. There was one month of low compliance rate of 88% reported in January 2013. Issues contributing to the low compliance rate were addressed and the compliance rates returned to 96% to 100% for the remaining reporting period. • The Emergency Response Committee was comprised of the following membership: Facility Director, Assistant Director of Programs, Assistant Director of Administration, Medical Director, CNE, NOO, Director of Residential Services, Director of Incident/Risk Management, CTD Director, Safety Specialist, QA Director, QA Nurse, and Worker Compensation Representative. It was positive to find that the membership was comprised of integrated leadership disciplines and administrative staff. • A review of Emergency Response/Drill Committee Meeting minutes, October 2012 through June 2013, showed Committee review and critiques of 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 performed at the end of the month as opposed to spreading out the drills throughout the month and took corrective action. All minutes reviewed consistently identified the need for Medical Emergency Drill Coordinator backup for QA and Nursing, although it was noted that QA and Nursing continued to work on securing backups. The Committee agreed to change the monthly committee meeting back to quarterly beginning in March 2013. • A review of the CTD Due/Delinquent Training List, 7/9/13, for CPR: Basic training showed three employees were delinquent. CPR for Health Care Providers showed three employees were delinquent. This was a significant improvement from previous compliance reviews. It is essential that the Facility continue to ensure that all employees are current with their respective CPR training. The Monitoring Team attended a Critical Incident meeting on 7/24/13, regarding the death of Individual #443. It was positive to find that along with other pertinent information discussed, the emergency response to the code was critiqued for lessons learned. As a result, improvements will be made to scenarios practiced during Mock Emergency Medical Drills. This change to the drills will be reviewed at the next compliance review.	

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		The Facility should continue the positive practices identified in the report to maintain substantial compliance with the Emergency Response Policy requirement for this Provision.	
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.	Monitoring Team Findings: The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.2's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, RN Case Manager Supervisor; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.2 and the Monitoring Team concurs with their findings. According the Facility's Self-Assessment, this Provision was not found in substantial compliance. The result of the Self-Assessment included but was not limited to: The Guidelines Quarterly Nursing Review/Quarterly Physical Assessment was updated, implemented, and trained in July 2013. The Compliance Nurse worked on a monitoring tool for the updated assessment but it was not implemented as of 6/30/13. The Self-Assessment stated that the monitoring data had decreased over the last few months related to changes in the monitoring tool and processes. The Self-rating for noncompliance was based on their findings and the need for improved consistency with this Provision. Based on a review of the nursing assessment reported below, the Monitoring Team concurs with their findings. New/Revised Policies, Procedures, Processes, Protocols: • DADS Guidelines: Comprehensive Nursing Review/Quarterly Record Review/Quarterly Physical Assessment, Date: April 2013 Training Activities: • In May 2013, 100% of the RN Case Managers were trained on the Guidelines: Comprehensive Nursing Review/Quarterly Record Review/Quarterly Physical Assessment. Since the last compliance review, several changes were made that impacted this Provision: • There had been turnover and replacement of four RN Case Managers. At the time of the compliance review there was one vacant RN Case Manager position. • The Diabetic Nurse Educator had assumed the position as the RN Case Manager Supervisor in February 2013. Through interview and review of summary activities performed related to her responsibilities, it appeared that her efforts had moved this Provision forward toward meeting compliance. However, as reported in the Self-Assessment, substantial compliance was not yet met. The RN Case Manager Supervisor's responsibilities included, coordination and oversight of the RN Case Managers caseloads,	Noncompliance

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		education and training of the RN Case Managers, coordination/integration of services with other disciplines/IDTs, and the fostering of leadership and professionalism. • The RN Case Manager Supervisor attended the IMR daily, took copious notes on individuals reported who required follow-up by the RN Case Managers and/or other relevant nursing staff, as validated through review of her notes/email communications, 7/8/13 through 7/24/13. In addition, the RN Case Manager had concertedly worked with the RN Case Managers to improve the timeliness and quality of annual and quarterly nursing assessments. Refer to Provision M.1, Quality Assurance for information regarding monitoring for nursing assessments. • The reporting form for the Comprehensive Nurse Assessment was revised and implemented on 6/1/13. The form's name was changed to Comprehensive Nursing Review. The physical assessment section was replaced with a Quarterly Nursing Physical Assessment form and a Quarterly Nursing Record Review form. The procedure for completing the Comprehensive Nursing Review included: Within 30 days of the date of admission. Annually, at least ten working days prior to the annual ISP. Upon return to the center, if the individual was absent from the facility for more than 30 days. The Nursing Physical Assessment form will be completed along with the annual or admission Comprehensive Review, at least quarterly along with the Quarterly Nursing Record Review form. These forms must be completed by the last day of the month in which the quarterly was due. Although the procedure and forms for the nursing assessments were changed, the Monitoring Team found that the actual content and requirements for compliance did not change significantly. The Monitoring Team reviewed the most recently completed Admission, Annual and/or Quarterly Comprehensive Nursing Assessments of a sample selected from the Facility's At Risk List for individuals identified at high risk health conditions and from each unit for 25 Individuals: Individuals #365, #279, #392, #242, #123, #331, #791, #783, #553, #228, #239, #379, #566, #34, #95, #694, #171, #605, #531, #665, #244, #704, #735, #463, and #304 and found: • The 25 most recently completed Admission, Annual, and/or Quarterly Nursing Assessments were completed timely 81% of the time as require by Facility policy. This was consistent with the Facility's Self-Assessment, which showed nursing assessments were completed timely 82% of the time in April 2013. • Twenty five of the last completed Annual and/or Quarterly Comprehensive Nursing Assessments were reviewed using a monitoring tool comparable to the tool previously used by the Facility found an overall compliance of 86%. This was relatively consistent with the Facility's findings last reported to the QA/QI Council in April 2013. Required items on the tool that fell significantly below 90% compliance, which needs continued improvement included: o Current active medical diagnoses were not consistently updated.	

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		o Assessments of all dates of last consults, recommendations, and summary analyses of data: Although the dates, results, and recommendations were documented relatively consistently, the summaries of analysis of data were not consistently documented and/or when data were summarized the documentation did not state the relationship the data had to individuals' health status. o All Diagnosis Testing/Screening, including dates due for: standing lab orders, frequency, abnormal results, dates of diagnostic tests, and/or procedures, and/or screenings, as well as summary analyses of data. Although the dates and results were documented relatively consistently, the summaries of analysis of data were not consistently documented and/or when data were summarized the documentation did not state the relationship the data had to individuals' health status. o All medications were listed showing doses, routes, reasons, responses, and effectiveness. Summaries included reviews of effectiveness of all medications and treatments: The medication doses, routes, reasons, responses, and effectiveness were listed relatively consistently, but the summary of analyses did not consistently contain reviews of effectiveness of all medications and treatments, i.e., psychotropic, anticonvulsant, antihypertensive, GI meds, diabetic meds, shampoos, sunscreens, use of behavioral chemical restraints, and MOSES/DISCUS scores and side effects. o Summary analyses of data relating to Nutrition and Weight Management, History, Functional and Psychosocial, and Physical Assessment: The actual clinical assessments of these data items were relatively consistently and sufficiently done. However, for items assessed that related to individuals' high/medium risks and/or active medical problems for which nursing was responsible, the summary analyses of data were not consistently documented, and/or when clinical data were summarized, the documentation did not consistently reflect the relation of individuals' health status to the data, i.e., were individuals improving/progressing, maintaining and/or regressing. o Section XI Nursing Summary: ▪ Reviews of health status from previous quarter/annual, including any surgeries were not consistently documented. ▪ Overall nursing summaries/analyses regarding individuals' health status in relation to identified high/medium risk rating and/or nursing diagnoses/problems as whether they were improving/progressing, maintaining and/or regressing, as well as the effectiveness of their health care plans: There was significant improvement in summarizing raw clinical data. However, the summarized documentation did not consistently reflect individuals' health status in relation to the data, i.e., were individuals improving/progressing, maintaining and/or regressing and the effectiveness of their health care plans.	

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		▪ Individuals' progress toward their Self-Administration Programs: This information was not consistently documented in the summaries. o Five of 25 (19%) nursing assessments reviewed by the Monitoring Team were completed on the new nursing assessment forms. It was evident from the review that the RN Case Managers needed continued experience in completing the nursing assessments on the new forms. The Facility's Self-Assessment, interviews with the Compliance Nurse and RN Case Manager, and review of documentation provided, showed that although the revised Nursing Assessment Monitoring Tool was not yet implemented, the RN Case Manager Supervisor was critically reviewing completed nursing assessment using the new procedure and forms, as well as providing feedback to the RN Care Managers. For the next six months the Nursing Department should consider focusing on improvements for the issues identified above in order to move toward compliance with this Provision.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.3's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, RN Case Manager Supervisor; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.3 and the Monitoring Team concurs with their findings. The Facility's Self-Assessment stated that the risk rating process and Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs) were reviewed and updated by the state office during the week of 9/5/12, for which they provided training to the RN Case Managers and Qualified Intellectual Disability Professionals (QIDPS). The Facility developed a shortened training module for the new ISP process and all associated forms. Training was provided to each unit during the month of January 2013. The new IHCPs were implemented on 2/1/13. A monitoring tool for IHCPs had not yet been developed. The Protocol Audit Tools were revised to include care plan audits during documentation audits. Protocol Audit Tools for eight categories were identified and implemented in March 2013. Monitoring for Acute Care Plans will be implemented by July 2013. The Acute Care plans will cover the same topics as the Protocol Card Audit Tools. The Self-Assessment stated that the monitoring data had decreased over the last few months related to changes in the monitoring tool and processes. The Self-rating stated that this provision was not in compliance due to the continued fine turning of these processes. <u>New/Revised Policies, Procedures, Processes:</u>	Noncompliance

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		• DADS At Risk System, Policy Number: CM 14 - Addendum H, Effective: 2/1/13 <u>Training Activities:</u> • On 9/5/12, all RN Case Managers and QIDPs were trained by the State Office staff on the revised risk rating process and Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs). The Monitoring Team's review of Skin Integrity Acute Care Plans for Individuals #242, #583, #750, #392, #743, and #323 found there was no significant improvement in the quality and the content of the plan. Perhaps, when the protocol cards are incorporated into the Protocol Care Audit Tools improvement will be found. • Four of six (67%) plans had baseline data sufficient to identify the skin integrity issue that led up to the necessity for care plans. • Five of six (83%) plans had goals sufficient to identify the desired outcomes of the skin integrity issues for which the care plans were designed to resolve. • Five of six (83%) plans were marginally modified from the generic care plans sufficient to meet the individuals' specific skin integrity issues. • Two of six (33%) plans included integration of care with other relevant disciplines. • Four of six (67%) plans included how frequently interventions were to be completed, by whom, and where documented. • Six of six (100%) included that DSPs were trained on the DSP Instruction Sheet. However, from the signature sheets it was not possible to discern whether all home managers and DSPs were trained on each shift, including whether newly assigned and/or pulled staff was trained on the plans. However, not all of the DSP instructions copied from the generic plans were applicable to individuals' specific skin integrity issues. For example: o Individual 242's instructions stated, "Report to nursing when masturbation occurs so that lubrication may be applied to prevent injury." Individual #242's plan was for management of altered skin integrity related to the G-tube stoma. If this was another skin integrity issue, a separate care plan should have been developed for this issue. o Individual #750's instruction state, "Encourage resident to stay off affect area or reposition at least every two hours." Individual #750's plan was for management of altered skin integrity related to the G-tube stoma. While proper repositioning is important, particularly to reduce pressure over bony body parts, unless Individual #750 had an issue with lying on her stomach, this instruction did not appear relevant to her skin integrity issue. The documentation reviewed in the individuals' above Integrated Progress Notes were far more complete and comprehensive regarding management of skin integrity issues/wounds, including wound assessments, status of healing, treatments, and communication and	

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		integration of services and supports with other disciplines, than were reflected in the care plans. If care plans are to be used functionally, they should include all actual interventions and should be revised consistently as the skin integrity issues status and/or interventions/treatment regimens change. Care plans should not merely be a perfunctory paper exercise. As recommended in past compliance reviews, the Skin Integrity Nurse should review all skin integrity/decubitus health care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals. The Monitoring Team's review of a sample of five individuals with recent and/or current active infections Acute Care Plans and supporting documentation for Individuals #211, #242, #719, #164, and #587 found: • Of the five individuals with recent and/or current active Acute Care Pans for infections only three care plans were provided for review: • One of three (33%) plans had baseline data sufficient to identify how infections lead to the necessity for care plans. • One of three (33%) plans had goals sufficient to identify the desired outcomes of the infections for which the care plans were to designed to resolve. • Two of three (67%) plans were marginally modified from the generic care plans sufficient to meet the individuals' specific diagnosed infections. • Two of three (67%) plans included integration of care with other relevant disciplines. • One of three (33%) plans included the frequency interventions were to be completed, by whom, and where documented. • Three of three (100%) included that DSPs were trained on the DSP Instruction Sheet. The DSP Instruction Sheets were sufficient to meet the individuals' care related to their specific infections. However, from the signature sheets it was not possible to discern whether all home managers and DSPs on each shift were trained, including whether newly assigned and/or pulled staff was trained on the plans. The documentation reviewed in the individuals' Integrated Progress Notes below were far more complete and comprehensive regarding management of infections according to Antibiotic Therapy Protocol and/or other related protocols for the specific infection. As recommended in past compliance reviews, the Infection Control Preventionist should review all infection care plans to ensure they are current and reflect the actual interventions carried out specific to the individuals' infections. Examples of findings from review of Integrated Progress Notes for Individuals #211, #242, and #719 found: • Individual #242 was diagnosed with a urinary tract infection and treated with antibiotic therapy on 7/19/13. It was positive to find in review of his Integrated Progress Notes for each shift, 7/19/13 through7/22/13, that both the Antibiotic Therapy and Urinary Tract Infection Protocols were followed sufficiently on each shift as required. • Individual #211 was diagnosed with H-Pylori on 7/10/13. It was positive to find in	

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		review of Individual #211's Integrated Progress Notes for, 7/10/13 through7/24/13, that the Antibiotic Therapy Protocol was followed precisely as required. • Individual #719 was diagnosed with C-Diff and treated with antibiotic therapy for 10 days. It was positive to find in review of Individuals #719's Integrated Progress Notes, 7/3/13 through 7/24/13, that both the Antibiotic Therapy and Contact Isolation Protocols were consistently followed through to resolution as required. The Monitoring Team's review of Nursing Discharge Summaries and Community Living Discharge Planning Packets for Individuals #359, #81, #183, #122, #763, and #67 found: • Four of six (67%%) assessments showed that comprehensive assessments for clinical indicators were completed for each specific health item contained on the Nursing Discharge Summaries within 45 days of discharge. The Comprehensive Nursing Assessment for Individuals #67 and #183 either were not included in the discharge packets for review or were not completed. • Six of six (100%) Nursing Discharge Summaries were completed for the individuals prior to discharge/transferring to the community. • Three of six (33%) individuals' health status in relation to each significant identified health clinical indicators was thoroughly summarized such that the receiving agency could understand their present health status in order to respond to their health care needs. • Two of eight (25%) individuals' Discharge Packets contained Integrated Risk Rating Assessments or Integrated Risk Rating Forms (IRRFs) within 45 days of discharge. • One of six (17%) individuals' Discharge Packets contained Active Risk Plan or Integrated Health Care Plans (IHCPs) updated within 45 days of discharge. • Six of six (100%) of the summaries completed included 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, signs and symptoms of pain, etc.). • Four of six (67%) provided training on health care plans sufficient to meet individuals' health care needs for identified high and/or medium risk rating and/or nursing diagnoses/problems, and recommendations for future health care needs. For two individuals, this was not provided or was inadequate: o Individual #359 had medium risk rating for weight and had a significant progressive weight loss over the past year although his dietary calories were progressively increased. He should have had a plan to critically monitor weight, as opposed to only weighing monthly without any other weight management plan. In addition, he had a medium risk rating for circulatory secondary to wearing compression stockings for edema. He	

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		should have had a plan that included instructions for correctly applying the stocking and instructions on how to monitor and report any sign and symptoms of circulatory impairment secondary to wearing the stockings. o Individual #183 was at medium risk for skin integrity and it was listed as a nursing problem, but it was not included on the list for training. He was rated at high risk for polypharmacy and it was listed as nursing problem, but it was not included on the list for training. • Six of six (100%) individuals' Community Living Discharge Plans showed documentation that the Facility RN Case Managers or designees provided health care related training to the receiving agency's nurse and/or other designated agency staff. As was found in previous compliance reviews, the Facility did not have instructions for completing the Nursing Discharge Summary form beyond the few instructions printed on the last page of the form related to special instructions. In addition, the format and content varied in each of the six Nursing Discharge Summaries reviewed. Therefore, it was not surprising to find the deficiencies identified above. For quality, continuity of care, and compliance with discharge planning requirements the same format and content should be included in all Nursing Discharge Summaries. The Most Integrated Setting Practices Policy contained no instructions that identified the RN Case Manager's role and responsibilities for completing the Nursing Discharge Summary form. To move toward substantial compliance during the next six months, the State Office Nursing Coordinator and Facility's Nursing Department should consider providing the RN Case Managers with guidelines and training for completing the Nursing Discharge Summary and associated health care plans for community placement. Further, for compliance purposes it would be useful to consider developing a monitoring tool for Nursing Discharge Summaries. Refer to Provision M.5 and Section I, Provision I.1 and I.2 for additional information regarding the risk rating process and Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs).	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Nursing Education information presented in the Facility's Self-Assessment through: Review of the Nursing Education information presented in the Section M Presentation Book; and meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, and Nurse Educators, Compliance Nurse. Related Self-Assessment data were updated while onsite. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.4 and the Monitoring Team concurs with their findings. <u>New/Revised State/Local Policies, Procedures, Processes, and Protocols:</u> • DADS Nursing Services Policy, Policy Number: 010.3 Effective: 6/17/13 Replaces: 010.2	Substantial Compliance

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- DADS Medication Administration Guidelines, Date: June 2013.

Training Activities:

- The Nurse Educators continued to maintain an excellent, comprehensive, and up to date Nursing Training Database that indicated the percentage of the nurses completing the required training, a date for completion was projected for nurses who had not completed the training, and included the overall percentages of nurses trained.
- The Monitoring Team's interview with the Nurse Educators and review of Section M.4 Presentation Book, Nursing Training Database, competency-based training materials and records, validated the training reported in the Facility's Self-Assessment. In addition, the Nurse Educator provided updates on the status of increased percentage of training that had occurred since the Self-Assessment was completed 6/20/13.

The required Annual Nursing Competencies were taught monthly to incumbent nursing staff throughout the year as well at new nurse orientation. The Monitoring Team's review of the Nursing Education Calendar showed the monthly schedule for each required nursing competencies. 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 2013 Annual Competency Training completed as of 7/24/13:

Annual Competencies as required by Competency Based Training Policy	Date Trained	Percentage Trained	Projected Completion Date	Protocol Cards Integrated into Training by Number*
G-Tube Insertion	12/2012	98%	9/30/13	#4
Skin Management and Wound Care	9/2012	88%	9/30/13	#1
Diastat/Pre/Post Sedation/REACT Score	11/2012	80%	9/30/13	#s: 1.9, 20 and 5
Medication Calculation Test	10/2012	99%	9/30/13	NA
Neurological Assessment	1/2013	98%	9/30/13	#s: 15 and 1
Urine Dipstik/Hemocult	3/2013	80%	9/30/13	NA
Procedural Test	2/2013	100%	Completed	#s: 1 through 23
Hospital, Transfer, and Discharge	4/2013	97%	9/30/13	#s: 23 and 1
MOSES/DISCUS RN Case Managers	1/2013	100%	Completed	NA
MOSES/DISCUS Clinical	Scheduled			NA

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		Manifestations of TD (non RN Case Managers)	for 8/2013				
		Annual RN Acute Care Plans	5/2013	88%	9/30/13	#1 plus specific issues	
		Annual LVN Acute Care Plans	6/2013	55%	9/30/13	#1 plus specific issues	
		Annual Assessments Constipation Protocol	7/2013	49%	1 plus specific issues	#s: 13 and 11	
		Additional Trainings:					
		RN Physical Assessment Class/Check-Off/Unit Check-Off	Completed with required incumbent RNs 5/13	100%	Ongoing with new RNs quarterly		
		MAN0100 Medication Administration for Individuals with Intellectual and Developmental Disabilities (I/DD)	Completed with incumbent nurses 5/13	100%	Ongoing monthly with nursing orientation		
		Documentation	Completed with incumbent nurses 5/13	100%	Ongoing monthly with nursing orientation	#s: 1, 15, 11, 13, 14, 12, and 21	
		Mosby Chapters for RNs:					
		Chapter 17 - Abdomen	9/2012	100%	Completed		
		Chapter 13 – Chest and Lungs	10/2012, then quarterly	94%	9/30/13		
		Chapter 21 Musculoskeletal	1/2013	92%	9/30/13		
		Chapter 22 - Neurological	5/2013	68%	9/30/13		
		Chapter 14 - Heart	Scheduled for 7/29/13				
		Chapter – Head and Neck	Scheduled for10/13				
		Chapter – Ear, Nose, and Throat	Scheduled for 1/14				
		*The protocol cards numbered and were integrated into the annual competencies as related to the specific competency taught. At the next compliance review, the Monitoring Team will review the database for the annual competencies not completed to ensure they were completed by the projected dates. The Nursing Department continued the Preceptor Program using high performing nurses to					

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		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. <u>Integrated Training:</u> • The Nurse Educators continued to teach the mandated Clinical Indicator Class during New Employee Orientation at CTD. • Training from Section I – Risk Rating: On 1/31/13, Unit wide risk training was provided to professional disciplines to provide a more in-depth overview for those who did not receive more comprehensive training in December 2012. • Training from Section C – Restraint Reduction: On 2/28/13, In-service training was provided to Nurse Managers and House Supervisors on changes to the new Restraint Checklist Forms. On 3/8/13, an example of an incomplete Restraint Checklist was provided to the RN Case Manager Supervisor to explain to the RN Case Managers when and how they could assist in moving the process in the right direction to accomplish timeliness and completion of restraint documents. She provided this information to the RN Case Managers. • Training from Section J – Psychiatry: MOSES/DISCUS retraining was provided to the RN Case Managers in January 2013. • Training from Section N – Pharmacy: On 2/28/13, the RN Case Manager Supervisor, Health Care Services Coordinator, and Compliance Nurse met with the Pharmacy Director regarding communication breakdown and updated procedure to track MOSES/DISCUS assessments. <u>Integration of the Nursing Education Program:</u> The Nurse Educator explained to the Monitoring Team how they integrated nursing education efforts and provided supporting documentation. The highlights included, but were not limited to: • Assessment and documentation training was integrated into all training units related to delivery of individuals' care. Critical thinking skills were built under the "When to Notify the PCP" and "When to Notify the RN" sections of the care plan unit. Communication with team members was integrated into every teaching unit that had to do with notifying the PCP and/or team members. • During new nurse orientation, care planning, SOAP charting, and teaching plans were integrated into the Care Plan Instruction Unit. The nurses were required to complete sample care plans for: PICA (included with the PICA Instruction Unit), Head Injury (included with Neurology Instruction Unit), and Conjunctivitis (included with the Infection Control Instruction Unit). • Nurses were taught to use references with each unit of instruction. The nurses were encouraged to seek answers to test questions by referring to Facility policies, and protocol	

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		cards. Nurses were expected to use approved abbreviations in their documentation. • The Nurse Educators were in the process of expanding training to include information on Developmental Disability Syndromes and related risks associated with those syndromes. Presently, a brief overview on Developmental Disability Syndromes was included in the Physical Assessment Class, but the Nurse Educators did not think the information was expansive enough to provide a good understanding of the syndromes and associated risk factors. This information was also provided to nursing students who tour the Facility. The expanded instruction on Developmental Disability Syndromes was another envisioned continuing education offering. Further, enhanced learning opportunities included G-tube training by adding a training film by the tube manufacture, Kimberly Clark. The film covered the care and maintenance of the stoma site. Each nursing office was provided with a G-tube troubleshooting chart. It also included Continuing Education Units (CEUs). At the end of the Mosby chapters on system assessments, the Nurse Educators review the respective chapter before testing. In addition, they have an embedded video clip and animation from the Mosby Evolve to enhance the review. During the Monitoring Team's tours on the units and Infirmary, casual observations were made that found all of the nurses carrying the full set of protocols on their person, as required. In addition, it was positive to observe one nurse in Cedar Falls, who was unaware of the Monitoring Team's presence, working at a desk charting with a set of protocol cards out as he charted in Individual #355's Integrated Progress Notes regarding the G-tube that had come out and was replaced. Although there was no specific protocol card for dislodgement and replacement of G-tubes, the documentation reviewed showed that the nurse consistently followed the Abdominal Protocol in completing the assessment, as well as other pertinent information related to the procedure. The Nursing Department recently began conducting Nursing Protocol Card Audits. Refer to Provision M.1 for Quality Assurance Activities regarding these audits. The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions. Care was consistent with protocols for antibiotic therapy, urinary tract infections, pain, and other conditions, assessment and documentation followed the protocols, and the requirements in various protocols for reporting to the medical practitioner were followed. Furthermore, the review of individuals' care did not reveal any significant inconsistencies with the protocols. The Facility's Self-Assessment stated they were in compliance with this provision. The Monitoring Team concurs that this Provision was in substantial compliance. As reported above substantial compliance was demonstrated through the Monitoring Team's independent review of the Section M Presentation Book, staff interviews, direct onsite observations of nursing care, and review of documents to verify that the Nursing Department had continued to	

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		maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.	
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.	Monitoring Team Findings: The Monitoring Team validated the Risk Management information presented in the Facility's Self-Assessment through: Review of the Risk Management information presented in the Provision M.5 section of the Presentation Book; review of documents requested; meetings/interviews with the Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, and RN Case Manager Supervisor; attendance at an ISP Meeting. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.5 and the Monitoring Team concurs with their findings. The Facility's Self-Assessment stated that the risk rating process and Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs) were reviewed and updated by the state office during the week of 9/5/12, that they and provided training on the revisions to the RN Case Managers and Qualified Intellectual Disability Professionals (QIDPS). The Facility developed a shortened training module for the new ISP process and all associated forms. Training was provided to each unit during the month of January 2013. The training emphasized integration and participation by all team members. The new IHCPs were implemented on 2/1/13. A monitoring tool for IHCPs had not yet been developed. After the initial training sessions the RN Case Manager Supervisor began randomly reviewing IRRFs and then provided feedback to the RN Case Managers. In addition, the RN Case Manager Supervisor started attending ISPs to mentor the process and provide input to team members on how to improve communication and discussion regarding IRRFs and IHCPs. The RN Case Managers are in different stages of adapting to and implementing the risk processes. The Self-rating stated based on the Self-Assessment; this Provision was not in substantial compliance. Based on review of IRRF and IHCPs, the Monitoring Team concurs with their findings. Individuals' unified/active records contained Health Management Plans (HMPs) as well as the IHCPs. It was difficult to discern which of the two types of plans were followed. The HMPs were to be discontinued as IHCPs were developed and implemented. The Nursing Department should consider removing any of the HMPs that were not longer in used from the unified/active records. It was positive to find that the Red Care Plan Notebooks had been revised to include the Integrated DSP Plans of Care. New/Revised Policies, Procedures, Processes: • DADS At Risk System, Policy Number: CM 14 - Addendum H, Effective: 2/1/13 Training Activities:	Noncompliance

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		• On 9/5/12, State Office staff trained all RN Case Managers and QIDPs on the revised risk rating process and Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs). The Monitoring Team attended the ISP/IRRF meeting for Individual #441 and found: • All relevant IDT members, including Individual #441 were present at the meeting. The QIDP facilitator created an organized and calm climate conducive to good interaction by the IDT. During the portion of the ISP leading to the risk rating section the facilitator effectively and efficiently lead the discussion, drawing out each IDT member into discussion, and then went back over some items and asked if there was anything more to add. Each member, including the individual's DSP contributed to the discussion and planning. • All staff who were present at the ISP were staff who worked with Individual #441. • Individual #441 was present but had to leave due to episode of coughing. His attending physician was present and immediately went over and assessed him, and then ordered him sent to the ER to rule out aspiration. He was subsequently admitted, diagnosed, and treated for congestive heart failure. He remained in the hospital on 7/26/13. The IDT continued with the meeting but will need to conduct Significant Change of Status Risk Assessment and follow-up ISPAs during hospitalization and upon discharge. • There was some general improvement in the IRRF process. The recently appointed RN Case Manager did an excellent job facilitating the risk rating discussion. She had previously prepared the draft IRRF from clinical data provided by relevant professional IDT members. As she reviewed the clinical data for each risk condition she elicited additional information from other team members. All team members participated in the risk discussion. The IDT used the Risk Level Guidelines when determining risk levels; however, for some of the risk ratings the IDT should have applied clinical judgment to data when rating risks. • Individual #441's active record was present at the meeting for reference. However, the Monitoring Team did not notice that it was used. The IDT appeared well acquainted with his physical and mental health conditions as well as any behavioral issues. • Although there were some lengthy discussions of some of the risk conditions, there was no general disagreement. • All risk ratings appeared appropriate except: Cardiac, Circulatory and Fluid Imbalance were rated low based on clinical data. However, as noted above with the hospitalization and diagnosis of congestive failure these risk ratings should be elevated to high. His risk for Skin Integrity was rated as medium. The Monitoring Team disagreed with this rating based on the clinical data presented, particularly a current BRADEN scale score of 12 for skin integrity. Such a score alone indicated the need to rate skin integrity high. This coupled with the historical data of skin infections of the g-tube stoma and groin, non-ambulatory status, and inability to reposition self independently, further supported the	

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		need for a high risk rating, although the clinical data appeared to indicate that effective supports and services were in place to address skin integrity issues. Although the risk guidelines were referred to in determining risks, the IDT needs to enhance skills in critical thinking regarding the interrelationship between the various risk conditions within a particular group of risk conditions, as well as the interrelationship between the various risk rating groups in order to accurately determine risk ratings. While the risk guidelines serve some useful purpose in assisting with risk level determination, the sole reliance on the guideline prohibits the IDT from independent/critical thinking. The Monitoring Team reviewed six recently completed Integrated Risk Review Forms and Risk Action Plans for Individuals #365, #279, #553, #566, #171, and #665 and found: • Individual #279's plan was excellent for management of chronic UTI's. Goal was appropriate, and functional and measurable objectives were incorporated into the ISP to measure efficacy of the plan. The interventions were appropriate and clinically sound and well integrated with relevant disciplines. The plan identified appropriate clinical indicators to be monitored and frequency of monitoring. • Individual #566's plan for osteoporosis was too general and nonspecific to meet clinical needs for prevention. The goal was not sufficiently adequate to measure the efficacy of the plan. The clinical indicators to monitor were not sufficient to assess health status. In general, as was found in past reviews, there was wide variation from unit to unit, and across the IDTs, in the formats used for ISPs, IRRFs, and IHCPs, as well as the quality of the clinical data used to support the risk ratings. The Facility needs to ensure consistency across all IDTs, as well as among disciplines, if compliance is to be achieved regarding the IRRFs and IHCPs processes. For the next six months, the IDT should consider enhancing skills in critical thinking regarding the interrelationship between the various risk conditions within a particular group of risk conditions, as well as the interrelationship between the various risk rating groups in order to accurately determine risk ratings.	
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	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Medication Administration information presented in the Facility's Self-Assessment through: Review of the Medication Administration information presented in the Provision M.6 section of the Presentation Book; review of documents requested; meetings/interviews with the Chief Nurse Executive, Nursing Operations Officer, Pharmacy Director, Clinical Pharmacist, Medical Director, QA Director, QA Nurse, Program Compliance Nurse, and Nurse Managers; attendance at the Pharmacy and Therapeutics Committee Meeting; inspections/observations of units' Medication Rooms; Review of Units' Medication Administration Notebooks; and conducted Medication Administration Observations. Relevant Self-Assessment data were updated during the onsite compliance	Substantial Compliance

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	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.	visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the Monitoring Team concurs with their findings. <u>Medication Administration Policies and Procedures:</u> • DSSLC Guidelines for Major Medication Review were reviewed, updated and approved by the PNMC. Date: 4/25/13 • DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 27.1, Revised: 4/24/13 <u>Medication Administration Training:</u> • Mandated Medication Administration for Individuals with I/DD, as of May 2013, 100% of the incumbent nurses had received this training. The training was provided ongoing in new nurse orientation. • Training was completed for all pertinent nurses responsible for medication administration as of 6/30/13. • Training was provided by the Pharmacy to pertinent nurses responsible for medication administration on Introduction to Binosto/alendronate on 12/7/12. • Annual MOSES/DISCUS training was completed for all RN Case Managers on 1/3/13. <u>Medication Variance and Pharmacy and Therapeutic Committees Meetings:</u> • The Monitoring Team reviewed the Pre- Medication Variance Committee Meeting Minutes, November 2012 through June 2013. The minutes included medication variance data aggregated, analyzed, and trended for nursing from the Units/Infirmary Prior to the Pre-Medication Variance Committee meetings; they aggregated the data and conducted detailed analyses, trends, and took corrective actions to mitigate medication variances. The QA Nurse conducted monthly Medication Administration Observations and provided monthly analyses, trends, and recommendations for corrective actions reports. These reports were presented at The Pre- Medication Variance Committee Pre- Medication Variance Committee was comprised of: The CNE/NOO (facilitator), Unit/Infirmary Nurse Managers, Pharmacy Director and QA Nurse. These reports were presented at the monthly Medication Variance Committee Meetings, which had a robust and comprehensive system for further analyzing, trending, and implementing corrective actions locally and systemically to mitigate medication variances. The Medication Variance Committee was comprised of: The Pharmacy Director (chair), Center Director, Medical Director, Director of Residential Services, CNE, NOO, and Director of Quality Assurance. • In addition the medication variance data were presented at the quarterly Pharmacy and Therapeutics Committee Meetings for further review, discussion, and disposition, as needed. The Monitoring Team reviewed the Pharmacy and Therapeutic Committee meeting minutes October 2012 through April 2013. Monitoring Team attended the	

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Polypharmacy Committee and Pharmacy and Therapeutics Committee meeting on 7/23/13. Refer to Section N for additional information regarding medication administration practices.

Medication Variance Reports:

The Facility continued to have a comprehensive Medication Variance Database using a root cause analysis approach. Medication Variance data was included for Nursing, Medical, Pharmacy, and Dental Department. The database contained aggregated, analyzed and trended data by: Month and quarter, Unit/Infirmary, apartment, campus-wide, shift, number of variances type and node, severity index by Categories A though I, nurses who committed the variances, individuals for which the variances were committed, contributing factors, and medications associated with the variance. The database also included Inspection and Storage data. The data were represented by bar graphs and tabular charts; including the number of variances represented, with 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 January 2013 through June 2013 that had been aggregated, analyzed, trended, along with remedial actions taken to mitigate medication variances and storage issues.

The Monitoring Team reviewed the total number of medication variances by severity index, reported January 2013 through June 2013, which showed:

Severity Index	Unidentified Other	A	B	C	D	E	F	G	H	I	Monthly Total
January	1	141	0	29	1	0	0	0	0	0	172
February	2	136	1	34	2	0	0	0	0	0	175
March	0	172	5	60	3	0	0	0	0	0	240
April	3	172	4	22	1	0	0	0	0	0	202
May	1	143	7	35	0	0	0	0	0	0	186
June	0	116	2	29	1	0	0	0	0	0	148
Total	7	880	19	209	8	0	0	0	0	0	1123

The Monitoring Team reviewed the total number of medication variances by department, reported January 2013 through June 2013, which showed:

Month	Unidentified	Medical	Nursing	Pharmacy	Dental	Other	Total
January	1	46	34	91	0	0	171
February	2	69	45	59	0	0	173
March	2	63	67	108	0	0	238
April	3	46	41	112	0	0	199
May	3	47	42	94	0	0	183

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June	0	36	41	71	0	0	148
Total	11	307	270	535	0	0	1123

It was evident since the last compliance review; the Facility had made significant improvements in reporting, analyzing, trending, and corrective actions taken to mitigate medication Variances. As the data above showed, all departments were reporting their medication variances, as expected; there was an increase in the number of medication variances as improvements were made in reporting medication variances. However, as systems were put in place to identify, report medication variances and put corrective actions in place, there was a steady decrease in the number of medication variances. The improvements made included but were not limited to the pharmacy and medical departments reporting medication variances, and when unreconciled excesses/shortages in medications were found they were reported as medication variances. Nursing, Pharmacy and Medical Departments began presenting category A medication variances in the data and graphs during the medication variance meetings, which previously was not done. Category A medication variance was defined as having potential to causes a variance, such as medications discovered before they left the pharmacy and/or the results of the Medication Administration Records not being initialed. Efforts were made to improve the timeliness and accuracy of data entered into the database.

The Monitoring Team 's review of the Facility's ten most recently completed Medication Variance Reports for Individuals #739, #290, #82, #32, #32, #579, and #222, found significant improvement in the completeness and accuracy of the reports:

- Ten of 10 (100%) reports were fully completed, and indicated the type of variance, severity index, physician notification, and were reviewed by the respective nursing supervisors.
- Ten of 10 (100%) reports showed that the respective nursing supervisors documented appropriate corrective actions.
- Ten of 10 (100%) reports showed the Pharmacy Department reviewed and commented on the reports.
- Ten of 10 (100%) reports were incorporated into the Medication Variance Database, and after an analysis was presented to the Medication Variance Committee for further review and disposition.

<u>Facility Medication Administration Observations:</u>
In December 2012, the Nursing Department began using the revised Medication Administration Observation form. The form contained "Essential Elements" that must be complied with 100%. Failure to comply with these elements required immediate retraining and follow-up observations. The Monitoring Team reviewed monthly overall Medication Administration Observation data completed by the Nurse Managers and inter-rater reliability

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		checks performed by the QA Nurse. In addition the QA Nurse summarized monthly the finding of items on the tool that scored less that 100% compliance. For those items scoring less than 85% compliance, she included recommendations for corrective action. The Medication Administration Observation data below shows the overall monthly percentage of compliance with the observation tool and level of agreement between the Nurse Managers and the QA Nurse, January 2013 through June 2013:	

Month	January	February	March	April	May	June
Percentage of Compliance	98%	99%	99%	98%	99%	99%
Inter-rater reliability	none	92%	96%	91%	98%	100%

In April 2013 systemic issues were identified regarding the nursing staff's lack of consistently referring to and following individuals' PNMPs and the failure to consistently use privacy screens during medication administration. Consequently, CAPs were developed and implemented. The Monitoring Team's review of the CAPs found they were completed 5/17/13.

Monitoring Team's Medication Administration Observations:

The Monitoring Team conducted medication observation in Cedar Fall at 12:00 noon, 7/23/13; Westridge at 12:00 noon, 7/14/13, and Timberhill at 4:00 p.m., 7/24/13, accompanied by the NOO and Unit Nurse Managers. Findings of the observation included:

- The nurses observed administered both oral and enteral medication in accordance with current, generally accepted professional standards of safe medication administration practices. There were a few minor instances when nurses were reminded by the NOO and/or Nurse Manager to ensure opened medication packages and/or bottles of liquid medication used were retained on the medication cart until after the third check was completed.
- It was positive to find that the nursing staff consistently reviewed individuals' PNMPs and checked for allergies before administering medication. However, two individuals' PNMPs that were updated recently were not replaced in their Medication Administration Records (MARs). The Nurse Managers immediately contacted the PNMT and were they replaced on the spot. The CNE subsequently directed the Nurse Managers to check all MARs to ensure and/or replace any updated PNMPs. By 7/25/13, nursing had audited 100% of the MAR Notebooks and all PNMPs were reported current.
- It was positive to find that Self-Administration of Medications (SAMs) Programs were consistently implemented. The nurses administering medication in Timberhill did an exemplary job in implementing individuals SAMs program. It was apparent through the observation that individuals knew their programs well. The individuals even teased the nurses by giving the wrong response as though they were testing the nurses, and then they laughed and gave the correct response. All the individuals had their unique desires

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		for when and how they received their medications. These two nurses exercised patience and fostered positive interactions while allowing individuals to receive their medications the way they wanted them. One of the nurse was a designated preceptor and the other nurse being considered to become a preceptor. • It was positive to find that the DSPs consistently assisted the nurses during medication administration. • None of the areas where medication administration was observed had a dedicated medication room to take individuals for privacy. Individuals who received medications enterally were administered medication in their room with privacy screens used in semi-private rooms. Some individuals were administered medications in an area less intrusive with the use of privacy screens, and in other areas medication rooms were created out of closets with Dutch doors over which medications were passed, using privacy screens to shield them from the open areas. The lack of dedicated medication rooms to provide privacy for individuals and freedom from distraction for the nurses administering medication has consistently been documented in all previous reports. According to the nursing administration they were continuing to work with the Space Committee on this issue. • A review of one MAR Notebook found two recently employed nurses' signatures were missing on the Universal Signature Sheet. The Nurse Manager promptly had the sheet updated. The Nurse Manager Monitoring Tool that was being piloted at the last review was fully implemented. The Nurse Managers audited their Units twice a month on a variety of items, which also included inspection of the medication room and medication carts, medication storage areas, MAR Notebooks, Narcotic/Control Drug Logs, and Glucometer Notebooks. The data provided in the Self-Assessment reported that over the last eight months findings for all items on the Nurse Manager Monitoring Tools had improved overall from 50% compliance to 85%. The Pharmacy department also conducted monthly inspection/storage audits on all units. If problems were found they were corrected on the spot and the inspection/storage data and disposition were reported in the Medication Variance Committee meetings. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6; the Monitoring Team found that significant improvement was made in both in medication administration practices and in the Facility's medication variances procedures and processes to track, analyze and provide local and systemic corrective action plans. Therefore, this Provision was found in substantial compliance. Although substantial compliance was found at this compliance review, the positive practices found must be maintained, and the Monitoring Team urges the Facility to continue to demonstrate effective steps over time to mitigate medication variances. Further, the positive medication administration practices and medication variances procedures and processes demonstrated by this Facility are exemplary	

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		to their peers and should be recognized as such.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/2013 2. DSSLC Action Plan 6/21/2013 3. DSSLC Presentation Book, Section N (undated) 4. DSSLC Pharmacy Policy 34.1, Process for Adverse Drug Reaction Reporting 4/10/2013 5. DSSLC Guidelines for Major Medication Review were reviewed, updated and approved by the PNMC. Date: 4/25/13 6. DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 27.1, Revised: 4/24/13 7. DSSLC Pharmacy and Therapeutic Meeting Minutes (P&TC) dated 2/29/2013, 6/25/2013, 4/3/2013, 7/23/2013 8. Quarterly Chemical and Behavioral Restraint Usage Report, dated 2/28/2013 9. Stat Medication Use Trend, dated 2011 through 2013 10. List of all individuals who were prescribed an antipsychotic medication and had diabetes and/or hypertension 11. List of all individuals who were diagnosed with metabolic syndrome 12. List of all individuals at risk for metabolic syndrome 13. List of all individuals who were prescribed: a. anticholinergics b. benzodiazepines c. psychotropic polypharmacy 14. Most recent two QDRRs, annual psychiatric assessment, annual medical assessment, most recent Individual Services Plan (ISP), and integrated risk assessment (IRRF), last six months labs, and current medication list for Individuals #703, #587, #90, #19, #774, #667, #182, #21, #790, #781, #630, #273, #351, #196, #352, #218, #116, #568, #170, #703, #231, #11, #367, #705, #279, #633, and #445 15. Benzo/Zolpidem/Zaleplon/Lunesta Trending Report (undated) 16. Anticholinergic summary (undated) 17. Polypharmacy Trends Analysis, 6/1/2009 through 6/1/2013 18. For the first new medication orders written in April 2013 (Individuals #14, #652, #56, #335, #769, #667, #293, #305, #720, and #347): a. Copy of medication order b. Documentation of pharmacist's review of the order c. Associated single patient drug intervention reports (SPDIs) d. Current medication list 19. Adverse Drug Reaction (ADR) reports, associated medical provider and nursing IPNs for Individuals #368, #575, #549, #4, #663, #192, #191, #443, and #248 20. Adverse Drug Reaction Reporting Tracking Spreadsheet, 2013 21. Medication variance report forms for Individuals #739, #290, #290, #82, #32, #32, #749, #37, #579,

	and #222 **People Interviewed:** 1. Jana Boone, R Ph, Pharmacy Director **Meeting Attended/Observations:** 1. Polypharmacy Committee 2. Pharmacy and Therapeutics Committee (P&TC)
	Facility Self-Assessment: The Monitoring Team recognized that the Facility used effective self-monitoring tools for Provisions N1, N2, N6, N7 and N8, of the Settlement Agreement. For Provision N.3, the Facility should assess that the QDRRs include specific review for polypharmacy, anticholinergics, benzodiazepines, metabolic syndrome, and stat chemical restraint; and ensure that there is appropriate review of the efficacy, appropriateness, dosing, and inclusion of recommendations for alternative treatments, when clinically appropriate. For Provision N.4, the Facility did not assess if the pharmacist developed, or did not develop, clinically appropriate recommendations for the medical provider, especially when considering recommendations made for the QDRRs, and SPDI. The pharmacist should also be assessed for whether he or she had acted upon the response made by the medical provider, to ensure that the response was clinically appropriate. For example, responses such as "will continue the medication because she was on it in the past" should always prompt a more measured response. The Facility's action plan identified many relevant action steps that will help lead the Facility closer to substantial compliance with Provision N; however, there are several sections that need additional well defined action steps. For example, an action step should be developed to ensure that pharmacists are well aware of the process for providing clinical recommendations, and how to appropriately follow-up on clinical recommendations when completing SPDI, and QDRRs. The Facility should consider reviewing comments made by the Monitoring Team for all sections of Section N, and develop action steps to address each comment, if the Facility believes that the comment is relevant, and requires an action step.
	Summary of Monitor's Assessment: The Monitoring Team noted continued improvement in working towards substantial compliance for Section N of the Settlement Agreement. Further development has been made, as the Monitoring Team determined substantial compliance for Provisions N.5 and N.8. The Facility maintained substantial compliance with all previous sections that were determined at prior visits to be in substantial compliance. Provisions N.2 and N3, are the only provisions not is substantial compliance; given the recent hire of clinical pharmacist, the Monitoring Team is confident that the Facility will continue to enhance its QDRR process. **Provision N.1:** The Facility continued to provide excellent review of new medication orders, and the Facility maintained substantial compliance with Provision N.1.

	Provision N.2: Because of staffing issues, the Facility reported that it was unable to maintain the QDRR schedule, and determined that the quality of the QDRRs were not adequate. Subsequently, the Facility requested that the Monitoring Team not review the Facility for compliance with Provision N.2, of the Settlement Agreement. The Monitoring Team was informed that a new clinical pharmacist was hired, and will immediately begin working towards Provision N.2 compliance. **Provision N.3:** The Monitoring Team is complimentary to the Facility for its judicious monitoring of polypharmacy, both at the systems and individual level. The QDRR process did not adequately document clinical rationale, potential risks, benefits, efficacy, and, when clinically appropriate, alternative treatment options. **Provision N.4:** The Monitoring Team recognizes that the Facility has recently hired a new clinical pharmacist, which should enhance the QDRR process by ensuring that appropriate recommendations will be well documented, and that responses by the medical providers are clinically justifiable. Also, the Monitoring Team did note that in all but one example, medical providers documented their review of what recommendations were made, on both the QDRRs and the SPDIs. For these reasons, the Monitoring Team will continue substantial compliance, with the understanding that these issues will be addressed at the time of subsequent reviews. **Provision N.5:** As per Provision J.12, the Monitoring Team noted improvements with completion of the DISCUS and MOSES assessments. Specifically, MOSES and DISCUS were obtained regularly, and when clinically indicated; and were reviewed, and completed by the medical provider; and indicated clinically relevant monitoring parameters, for the monitoring of tardive dyskinesia. Because the Facility maintained a functional process to assess for tardive dyskinesia, the Monitoring Team determined substantial compliance with Provision N.5. **Provision N.6:** The Monitoring Team continues to be impressed by the Facility's ADR process, and anticipates additional improvements with reporting of ADRs upon subsequent reviews. The Monitoring Team is complimentary to the Facility for following up on ADRs that occurred while individuals were hospitalized. The Facility continues substantial compliance with Provision N.6. The Facility should consider a process to ensure that the legally authorized representative is made aware of any ADR that requires medical attention. **Provision N.7:** Because the Facility continued to maintain an effective Drug Utilization Evaluation (DUE) process, the Monitoring Team concluded that the Facility remained in substantial compliance. **Provision N.8:** The Facility developed, implemented, and maintained a robust process to track, trend, analyze, and implement corrective action, when necessary, for medication variances. The Facility's database for tracking mediation variances is robust, and not only delineates the severity of variances, but identifies the relevant department, and staff member who was responsible for the variance. The

	medication variances committee consists of leadership from all relevant departments, including nursing, pharmacy, and medical. There was evidence to indicate meaningful action steps to help mitigate medication variances in the future. The Monitoring Team is complimentary to the Facility for developing, implementing and maintaining a robust medication variances process, and determined that the Facility is in substantial compliance with Provision N8.

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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 continued compliance with Provision N.1, the Monitoring Team reviewed copies of the first ten new medication orders, written in April 2013, along with associate single patient drug intervention reports (SPDI); pharmacy documentation that a review for allergies, interactions, appropriate indication, and dose; past six months laboratory data; current medication list; EKG for past three years; and most recent ophthalmology consultation. Review of the requested documents for Individuals #14, #652, #56, #335, #769, #667, #293, #305, #720, and #347, indicated the following: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, and indications in ten out of ten cases (100%) • The Monitoring Team reviewed the medication order for potential drug interactions with the current medication list, and in ten, out of ten cases (100%), the Monitoring Team identified no evidence of drug-drug interactions that were not reported to the physician. Because of proactive prescribing practice on the part of the medical provider, there were no instances when the pharmacist was required to initiate an SPDI. The following is an example of the Monitoring Teams consistent findings, when reviewing new medication orders: • Individual #293 was to start the antibiotic Ceftin, for a urinary track infections, and not only did the medical provider order a follow-up urinalysis, but also initiated an order to hold two medications, which if not held, may have resulted in a drug interaction. The Monitoring Team is complimentary to the pharmacy, and medical provider, for ensuring this type of proactive practice at the Facility. The Facility continued to provide excellent review of new medication orders, and the Facility maintained substantial compliance with section N.1, of the Settlement Agreement.	Substantial Compliance
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist	Because of staffing issues, the Facility reported that it was unable to maintain the QDRR schedule, and determined that the quality of the QDRRs were not adequate. Subsequently, the Facility requested that the Monitoring Team not review the Facility for	Noncompliance

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	shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	compliance with Provision N.2. The Monitoring Team was informed that a new clinical pharmacist was hired, and will immediately begin working towards Provision N.2 compliance. Compliance will require that QDRRs are completed timely, and address drug indication; potential and realized adverse reactions; appropriate dosing, and administration; efficacy' polypharmacy, the use of stat medications; review of anticholinergic medications; and the use of scheduled benzodiazepines, and related drugs.	
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 the Pharmacy's ability to monitor and address stat medication use, metabolic syndrome, use of benzodiazepines, polypharmacy, and the use of anticholinergic medications, the Monitoring Team discussed the provision with the pharmacy director, reviewed the presentation book, and requested the following clinical information: • List of all individuals who were prescribed an antipsychotic medication and had diabetes and/or hypertension, and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk of metabolic syndrome • List of all individuals who were prescribed an anticholinergic and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk of anticholinergic medications. • List of all individuals who were prescribed benzodiazepines and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk associated with the use of benzodiazepines. • List of all individuals who were prescribed psychotropic polypharmacy, and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk of psychotropic polypharmacy. • List of all individuals who were prescribed a stat psychotropic medication for a behavioral indication and, for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT specific to the use of the stat psychotropic medication, including a copy of the Face-to-Face form.	Noncompliance

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		• Copies of all data, data analysis, reports, committee meeting minutes, action plans and follow-up on action plans, used as part of a systems review for the system issues secondary to the use of benzodiazepines, anticholinergics, stat chemical restraint, polypharmacy, and metabolic syndrome. Metabolic Syndrome: The Monitoring Team was informed by the pharmacy director that the Facility had not develop a mechanism to provide a systems review for metabolic syndrome, and raised concern the current QDRRs did not fully address metabolic syndrome. As part of the document request, the Monitoring Team reviewed eight unique sample cases (Individuals #703, #587, #90, #119, #774, #667, #182, and #21), and determined the following outcome (note that the Facility provided ten samples, but two of the ten individuals were duplicates): • The QDRR documented recommendations to monitor for the development or worsening of metabolic disorder in zero out of eight cases (0%). • The QDRR documented all necessary risk indicators for metabolic syndrome (abdominal girth, diagnosis or treatment for hypertension, diabetes, hypertriglyceridemia) in five out of eight cases (63%). • The ISP clearly discussed the risks associated with the use of an antipsychotic medication and metabolic syndrome, and the risks associated with metabolic syndrome in in zero out of eight cases (0%). • The psychiatric assessment clearly documented the risks associated with metabolic syndrome, and the potentiating factor of antipsychotics in zero out of eight cases (0%). • The annual medical assessment documented the use of the antipsychotic as a potential risk for metabolic syndrome in zero out of eight cases (0%). The follow are examples of the Monitoring Teams findings, and concerns, regarding metabolic syndrome, and the use of antipsychotic medication: • Individual #703 was prescribed an antipsychotic medication, and was known to have diabetes mellitus, dyslipidemia, obesity, and an abdominal girth greater than 35 inches, and diagnosed with "pre-hypertension". There was no documentation on the QDRR, dated 6/12/2013, discussing the issue of metabolic syndrome, such as risk/benefit of continued treatment with the antipsychotic, and recommendations to either continue the medication or consider alternative treatment. Metabolic risk was not discussed on the most recent annual medical assessment, and the only comment made on the most recent psychiatric assessment was "Discussed decreasing Seroquel in view of metabolic syndrome"; however, there was no further discussion about risk/benefits, and	

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		the Individual was continued on the current dose of Seroquel. The most recent annual individual support plan (ISP), dated 5/28/2013 did not address the risks associated with metabolic syndrome, and did not consider the issue of continuing a neuroleptic in an individual with diabetes, obesity, increased abdominal girth, pre-hypertension, and dyslipidemia. The ISP did document issues such as hyperlipidemia, diabetes, and polypharmacy, but did not consider the use of an antipsychotic as a potential risk factor for any of the conditions mentioned. • Individual #90 had diabetes, morbid obesity, hypertension, dyslipidemia, and was on an antipsychotic. The most recent QDRR did not document risks associated with metabolic syndrome, or provide recommendations, such as the need to continue on the antipsychotic, or consider alternate treatment. The most recent annual medical summary documented metabolic syndrome but did not comment of risks of metabolic syndrome, or that the antipsychotic could be potentiating the condition. The most recent annual ISP documented metabolic syndrome, and the potential correlation between Risperdal and metabolic syndrome. The IDT decided to cross taper Risperdal with Abilify, but did not comment on the metabolic risks associated with Abilify. The Team must be aware that Abilify is also associated with risk factors for metabolic syndrome, including obesity, and severe hyperglycemia. The integrated risk discussion, dated 1/18/2013, did comment on the seriousness of the Individual's glucose control, obesity, hypertension, dyslipidemia, and history of chest pain, but the annual ISP, and most recent IRRF did not include a statement about the possible risks of continuing an antipsychotic medication, and such known conditions. The most recent IRRF, dated 1/18/2013 noted that the Individual had a diagnosis of metabolic syndrome, but did not address the risks of metabolic syndrome secondary to continued use of an antipsychotic medication. • Individual #119's QDRR indicated "Diagnosis of MS", but did not discuss risks associated with metabolic syndrome, and use of an antipsychotic, and no rationale or recommendations listed to continue the medication, or consider specific alternative medications. The most recent psychiatric assessment did discuss issues associated with continued use of the antipsychotic medication, and metabolic syndrome, and the psychiatrist was attentive to the issue of metabolic syndrome. The most recent ISP documented risks associated with the antipsychotic and metabolic syndrome and need to closely monitor the Individual, as documented on the annual psychiatric assessment; however, there was no discussion about risks, monitoring parameters, and possible alternative treatments listed within the context of the integrated risk assessment. • Individual #667's QDRR provided no comment on the potential risks associated with the antipsychotic and developing metabolic syndrome. Given that the	

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		Individual had weight gain, was diagnosed with hypertension, and had elevated triglycerides, the QDRR should have provided recommendations to the medical provider and IDT, to at least closely monitoring the Individual for possible development of metabolic syndrome. Also, the most recent ISP, dated 7/23/2013, indicated that the Individual's abdominal girth had increase to 42.5 inches, and this issue was not identified on the QDRR, which was completed on 7/19/2013, and utilized by the IDT for the ISP dated 7/23/2013. The most recent IRRF, dated 7/23/2013 did comment about metabolic syndrome, but there was no correlation with the prescribed antipsychotic. • Individual #182's QDRR documented "apparent metabolic syndrome", but no recommendations. The most recent IRRF had a section for assessing for metabolic syndrome, but none of the known risk factors were indicated on the IRRF. The QDRR is responsible for identifying inappropriate use of medications, ensuring that adverse outcomes and potential adverse outcomes from medication use are closely monitored, and assessing efficacy of medication related treatments. In addition, the reviewing pharmacists should provide clinical recommendations for alternative treatment, when clinically appropriate. The Facility, by professional assessments, such as the QDRR, psychiatric, and medical evaluations, assesses the risks associated with metabolic syndrome, and potential causes of metabolic syndrome, including antipsychotic medication use. Furthermore, the ISP must document all risks associated with metabolic syndrome, including medications that may hasten metabolic syndrome, and when necessary develop action plans to help mitigate the risk associated with development and potential development of metabolic syndrome. Although metabolic syndrome had been better identified, and documented on many of the annual medical assessment reviewed, the Monitoring Team determined that the QDRRs did not adequately document risks and benefits associated with the use of antipsychotic medications, and the associated risks of metabolic syndrome. Furthermore, the QDRRs did not offer meaningful recommendations, such as the need to closely monitor for the potential development of metabolic syndrome, and when clinically appropriate, offer alternative treatment considerations. STAT Chemical Restraint: The pharmacy director informed the Monitoring Team that the Facility provided no STAT chemical restraints during the past six month period; therefore, the Monitoring Team was unable to review its clinical process for monitoring the use of STAT chemical restraints. The Monitoring Team was provided trends data for the Facility's use of all stat	

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		medications, including stat medications for seizure control and hypoglycemia; however, trends data for longitudinal analysis of stat chemical restraint was not provided. From review of the STAT Medication Usage Report for 1/1/2013 through 2/28/2013, the Monitoring Team noted that three individuals (Individuals #102, #4, and #572) were provided a stat dose of Ativan for diagnosis of pain. The pharmacy department identified the issue, and addressed it with the medical provider. The Monitoring Team considers that the stat use of a benzodiazepine, used to control behavioral symptoms, is a stat chemical restraint, and should be documented as such. Also, the Monitoring Team is concerned with the practice of prescribing Ativan for abdominal pain, unless there is clear and rational clinical explanation for such use. As demonstrated by review of the P&TC minutes, dated 6/25/2013, the Facility does review the usage of stat medications, as part of a Quarterly Chemical and Behavioral Restraint, and Other STAT Medication Usage report. This report, which was documented on the P&TC minutes, provided an excellent trends analysis for the use of stat medications. The minutes reflected the inappropriate documentation for three administrations of Ativan, and documented what actions had been taken to rectify the issue. The Monitoring Team is complimentary to the Facility for its comprehensive review of stat medication use. Benzodiazepine Use: The Facility tracked the use of benzodiazepines for all uses, including neurological and psychiatric indications. Review of the Benzo/Zolpidem/Zaleplon/Lunesta Trending Report for the past eight month, indicated careful assessment of individuals prescribed scheduled benzodiazepines. As of July 1, 2013 the Facility reported that 13 individuals were prescribed a benzodiazepine for a neurological indication, and 26 individuals prescribed a benzodiazepine for a psychiatric indication. Based on a census of 484 individuals, the Facility administers scheduled benzodiazepines to 5% of the individuals who reside at the Facility, for a psychiatric indication. Review of the P&TC minutes for 4/3/2013 indicated that the Facility provides a quarterly systems review for the use of benzodiazepines, that includes an analysis of specific date, and trends. Review of the clinical documents, per the document request, the Monitoring Team made the following determination, for Individuals #790, #781, #630, #273, #351, #196, #352, #218, #116, and #568: • In five out of ten cases (50%), the QDRR documented the use and indication for the use of a benzodiazepine. • In zero out of ten cases (0%), the QDRR documented risks, benefits, efficacy or	

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		lack of efficacy, for the use of benzodiazepine. • In zero out of ten cases (0%), the QDRR documented whether the dose of the benzodiazepine was clinically justifiable. • In zero out of ten cases (0%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. The Facility provides appropriate tracking, trending, and trends analysis, for system issues related to benzodiazepines; and when issues were identified through trends analysis, they were addressed at the P&TC. The Monitoring Team is complimentary of the low number of individuals prescribed scheduled benzodiazepines for psychiatric indications. The QDRR process did not include a meaningful review of benzodiazepine use, and the pharmacist did not provide meaningful recommendations, specific to the issue of benzodiazepine use, on the QDRR. Anticholinergic Use: The pharmacy department tracked, and trended the use of anticholinergic medication use at the Facility. Review of the data, as listed on the anticholinergic Summary form, indicated that a total of 122 individuals were prescribed an anticholinergic medication. The use of anticholinergic medications prescribed at the level of the individual was discussed as part of the Psychoactive Medication Review meeting, and as reported by the pharmacy director, each individual is reviewed at least two times per year. Review of the Psychoactive Medication Review Meeting minutes, dated May 2013, indicated a comprehensive review by the Facility, of the rationale for the use of anticholinergics. The Facility also documented a review of trends analysis, quarterly at the P&TC meeting. Review of the 7/23/2013 P&TC minutes indicated a systems review of anticholinergic use, along with specific action plan, assigned person for the action plan, and due date for the action plan. From review of the clinical documents, per the document request, the Monitoring Team made the following determination, for Individuals #170, #703, #231, #11, #367, #705, #279, #633, #587, and #445: • In eight out of ten cases (80%) the QDRR documented the use and indication for the use of anticholinergics. • In eight out of ten cases (80%), the QDRR documented risks for the use of anticholinergics. • In zero out of ten cases (0%), the QDRR documented whether the dose of the anticholinergics was clinically justifiable. • In four out of ten cases (40%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or	

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		consideration for alternative treatments; however, it should be noted that the recommendation was within the body of the QDRR, and not listed as a formal recommendation. All recommendations should be listed under the heading "recommendations." • In zero out of ten cases (0%), the pharmacist documented the efficacy, or lack of efficacy for the use of anticholinergics. The Monitoring Team observed that the Facility tracks, trends, analysis and when necessary, initiates action steps to address issues related to anticholinergic use. Through the Psychoactive Medication Review meeting, the Facility periodically evaluates the use of anticholinergics, at the level of the individual, and provides recommendations to address anticholinergics. The QDRR did not provide a meaningful review, or specific recommendations for the use of anticholinergics. Polypharmacy: The pharmacy department tracked and trended data, specific to the use of polypharmacy at the Facility, for both a systems assessment and at the level of the individual. Systems data is reported quarterly, at the P&TC meeting. Review of the P&TC meeting minutes, dated 6/25/2013, indicated the use of intraclass polypharmacy for psychiatric indication had stabilized at 154 individuals (32% of population), and that the influx of new individuals to the Facility is resulting in an increased number of individuals receiving anticholinergics, as they are usually admitted on polypharmacy. The polypharmacy meeting minutes demonstrated an excellent review, along with clinically relevant recommendations, to help minimize the use of polypharmacy at the level of the individual. • In ten out of ten cases (100%) the QDRR documented the use and indication for the use of polypharmacy agents. • In one out of ten cases (10%), the QDRR documented serious risks for the use the polypharmacy combination. • In two out of ten cases (20%), the QDRR documented whether the dose of the anticholinergics was clinically justifiable. • In zero out of ten cases (0%), the QDRR documented clinically justifiable recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. • In one out of ten cases (10%), the pharmacist documented the efficacy, or lack of efficacy for the use of anticholinergics. The Monitoring Team is complimentary to the Facility for its judicious monitoring of polypharmacy, both at the systems, and individual level. The QDRR process did not adequately document clinical rational, potential risks, benefits, efficacy, and when	

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		clinically appropriate, alternative treatment options.	
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 the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the QDRRs from Provision N.3, and requested the following information for the first ten new medication orders written in April 2013: • Copy of medication order • Documentation of pharmacist's review of the order • Associated single patient drug intervention reports • Current medication list Review of the requested documents for Individuals #14, #652, #56, #335, #769, #667, #293, #305, #720, and #347 indicated the following: • The pharmacists clearly documented the potential drug-drug interaction in ten out of ten cases (100%). • The medical provider responded to the pharmacist's notification in ten out of ten cases (100%). • The medical provider indicated clinically appropriate rationale for continuing a medication with a known interaction, or provided alternate therapy in six out of ten cases (60%). o As noted on the SPDI report for Individuals #739, #404, #170, and #590, the Monitoring Team was concerned over the use of QTc prolonging agents, such as certain antibiotics, in medication regimens that include antipsychotics, which also have QTc prolonging effects. When the medical providers indicated to continue the drug combinations, there was no evidence that the individuals would be monitored more closely, or that the team was made aware of the potential risks. o The pharmacist did not question unjustified responses by the medical provider The following are three examples of appropriate clinical responses to the pharmacists' recommendations: • Individual #347, the medical provider indicated "Lisinopril is very low dose, and renal protection outweighs this risk", and the individual "is scheduled to have regular labs to monitor the side effects." • Individual #46, the medical provider documented clinically appropriate rationale for continuing the medication. • Individual #457, the medical provider changed the antibiotic, to prevent QTc prolongation.	Substantial Compliance

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		The Monitoring Team expects the pharmacists to assess the response to all SPDI recommendations, and when not clinically justifiable, either follow-up with the prescribing medical provider, or raise the issue with the pharmacy director. The Monitoring Team reviewed the QDRRs for Individuals #703, #587, #90, #19, #774, #667, #182, #21, #790, #781, #630, #273, #351, #196, #352, #218, #116, #568, #170, #703, #231, #11, #367, #705, #279, #633, and #445. It was noted that in 26 out of 27 cases (96%), the medical prescriber/s indicated that they concurred with the pharmacist's recommendation, and in the one case that the medical prescriber did not agree, a clinically rational response was documented. The Monitoring Team noted that for the majority of the cases reviewed, the pharmacists did not develop meaningful recommendations for important issues noted within the body of the QDRR. For example, when there was presence of metabolic risk, there were no recommendations for possible alternative treatments, or need for enhanced monitoring; also, the pharmacist would identify a need for a clinical action within the body of the QDRR, but not indicate the recommendation, under the heading "recommendations". The Monitoring Team recognizes that the Facility has recently hired a new clinical pharmacist that will enhance the QDRR process by ensuring that appropriate questions will be well documented, and that responses by the medical provider's are clinically justifiable. For this reason, the Monitoring Team considers that most requirements of this provision continued to be met, and areas of needed improvement constitute a temporary failure to comply during a period of otherwise sustained compliance. Therefore, this provision will continue to be found substantial compliance, with the understanding that these issues will be addressed at the time of subsequent reviews.	
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. As per Provision J.12, the Monitoring Team noted improvements with completion of the DISCUS and MOSES assessments. Specifically, MOSES and DISCUS were obtained regularly, and when clinically indicated; reviewed, and completed by the medical provider; and indicated clinically relevant monitoring parameters, for the Monitoring of tardive dyskinesia.	Substantial Compliance
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	To assess the Facility's ADR process, the Monitoring Team reviewed the first ten ADRs that occurred beginning 2/1/2013; reviewed updated policies and procedures for ADRs; and all data, trends analysis, summary review, and committee meeting minutes related to a system review of ADRs at the Facility.	Substantial Compliance

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	up remedial action regarding all significant or unexpected adverse drug reactions.	For the past six months period, the Facility's spreadsheet for ADR tracking indicated that during that period, eight ADRs occurred during an acute hospitalization, and 13 ADRs occurred at the Facility. All ADRs were reviewed by the pharmacist, who developed data analyses and summaries of the ADRs, which were then presented to the P&TC for further review. The Monitoring Team's review of the last six months' P&TC meeting minutes reflected the Facility's robust documenting on known and reported ADRs. For the past six month period, the Facility's spreadsheet for ADR tracking indicated that eight ADRs occurred during an acute hospitalization, and 13 ADRs occurred at the Facility, for a total of 21 ADRs, which was a 62% increase in reporting of ADRs, since the previous review period. The physician reported eight out of the 21 (38%) cases, direct care staff reported two out of 21 (9%) cases, nursing staff reported three out of 21 (14%), pharmacists reported 5 out of 21 (25%), and 3 out of 21 (14%) were reported by outside hospitals. Review of the P&TC minutes for 6/25/2013, indicated that the Facility conducted its review of all newly reported ADRs. The Facility revised its Pharmacy Policy 34.1, Process for Adverse Drug Reaction Reporting, on 4/10/2013, so that the procedure delineated the Facility's process to inform healthcare providers about ADR's; and defined the role of medical, nursing, pharmacy, and direct support healthcare personnel in ADR reporting and providing ADR reports to the executive formulary committee, Federal Drug Administration, and manufacturers, when appropriate. The Monitoring Team reviewed training information designed for direct care staff on the reporting of ADRs. The training material was relevant, and informative, and documentation of training indicated that 100% of the Facility's direct care staff, 1002 staff members, were trained on reporting of ADRs. The Monitoring Team is most complimentary to the Facility for its dedication to enhancing the reporting of ADRs. The Monitoring Team reviewed the first ten ADRs that occurred beginning February 1, 2013, that indicated the following: • Ten out of ten ADRs (100%)were reported using the ADR reporting form. • Ten out of ten ADRs (100%) were assessed by either the medical provider, or nurse. • Ten out of ten ADRs (100%) were reviewed by the pharmacy department.	

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		• The severity index was completed on the ADR form in six out of ten (60%) cases. • A description of the clinical findings was reported on the ADR form in ten out of ten (100%) cases. • The type of treatment provided for the ADR was documented on the ADR form in 9 out of ten (90%) cases. • The reason why the offending medication was used, was documented on the ADR form in seven out of ten (70%) cases. • Ten out of ten ADRs (100%) were reported at the P&TC meeting (2/29/2013, 6/25/2013, 4/3/2013, 7/23/2013). The Monitoring Team continues to be impressed by the Facility's ADR process, and anticipates additional improvements with reporting of ADRs upon subsequent reviews. The Monitoring Team is complimentary to the Facility for following up on ADRs that occurred while individuals were hospitalized. The Facility continues substantial compliance with Provision N.6, of the Settlement Agreement. The Facility should consider a process to ensure that the legally authorized representative is made aware of any ADR that requires medical attention.	
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 continued compliance for Provision N.7, as meaningful drug utilization evaluations (DUEs) were completed both as scheduled, and when clinically relevant. Review of the pharmacy department's schedule for DUEs indicated that during the review period at total of two planed DUEs were initiated: for Botox, and for Metformin. In addition, the pharmacy provided three unplanned DUEs; Restasis, Vesicare, and Nexium. The Monitoring Team evaluated the Facility's ability to address FDA alerts and warnings, and noted that the Facility had provided clinically appropriate information for the medical and pharmacy staff regarding the ten FDA advisories, that occurred during the reporting period; Fenofibrates, Aithromax, PPI's, Singulair, Cefepime, Plavis, Carbamazepine, Sertraline, Oxcarbazepine, and Zolpidem. Because the Facility continued to maintain an effective DUE process, the Monitoring Team concluded that the Facility remained in substantial compliance.	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	The Monitoring Team reviewed the Facility's medication variance process by reviewing medication variance data, and trends analysis; medication variance committee minutes for November 2012 through June 2013; P&TC minutes from January 2013 through May 2013; and medication variance report forms Individuals #739, #290, #290, #82, #32, #32, #749, #37, #579, and #222. Compliance issues were also reviewed as a component for Provision M.6, and the reader is referred to that section for additional insight into the	Substantial compliance

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	action regarding actual and potential medication variances.	Facility's medication variance process. Review of the medication variance report forms completed for the first ten medication variances that occurred in May 2013 (Individuals #739, #290, #290, #82, #32, #32, #749, #37, #579, and #222) indicated the following: • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in ten out of ten (100%) examples. • The department supervisor documented appropriate corrective action in ten out of ten (100%) examples • The pharmacy department reviewed, and commented on ten out of ten (100%) examples. • Medication variances were incorporated into the medication variance database, and after analysis was presented to the medication variance committee for review in ten out of ten (100%) examples. The Facility developed, implemented and maintained a robust database to track and trend medication variances. Medication variances were well classified by severity and by specific medical, pharmacy, dental nursing, and "other" departments. There were a total of 1,123 variances reported from January 1, 2013 through June 2013; 880 variances were category A, 19 were category B, 209 were category C, and eight were category D. The reader is referred to Provision M.6, for a comprehensive breakdown of all reported medical variances. The medication variance committee meeting minutes for November 2012 through June 2013 reflected a comprehensive trends analysis, along with documentation of specific action plans that were developed and implemented to appropriately address medication variance, and there was documentation to indicate that the action plans were followed through complete implementation. The Facility updated its DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 27.1, on 4/24/2013, and upon review, the Monitoring Team noted that the Facility had followed its policy for its tracking, trending, and reporting on medication variances. The Facility's medical director, pharmacy director, and nursing director, in addition to other disciplines, including the director of residential services, and director of quality assurance, all participate at the monthly medication review committee, and document on the medication variance committee meeting minutes their respective department's medication variance issues, including remediation action, and necessary system improvement initiatives.	

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		Summary: The Facility developed, implemented, and maintained a robust process to track, trend, analyze, and implement corrective action, when necessary, for medication variances. The Facility's database for tracking medication variances is robust, and not only delineates the severity of variances, but identifies the relevant department, and staff member who was responsible for the variance. The medication variance committee consists of leadership from all relevant departments, including nursing, pharmacy, and medical. There was evidence to indicate meaningful action steps to help mitigate medication variances in the future. The Monitoring Team is complimentary to the Facility for developing, implementing and maintaining a robust medication variances process, and determined that the Facility is in substantial compliance with Provision N8.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: 1. DSSLC Self Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 3. Presentation Book for Section I, Section O, and Section P 4. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 6/17/13) 5. Universal Monitoring Plan rev: 1/15/13 6. Record reviews: a. Sample O.1: Individuals #42, #66, #92, #101, #211, #218, #228, #463, #492, #499, #565, and #739 b. Sample O.2: Individuals #42, #66, #92, #101, #211, #218, #228, #492, #565, and #739 c. Sample O.3: Individuals #66, #92, #101, #136, #211, #218, #292, #571, #633, and #739 d. Sample O.4: Individuals #4, #82, #91, #118, #211, #228, #240, #247, #271, #289, #334, #335, #339, #351, #382, #409, #509, #543, #557, #632, #652, #707, #719, and #776 e. Sample O.5: Individuals #21, #33, #37, #55, #60, #66, #79, #134, #164, #165, #167, #192, #278, #286, #321, #386, #398, #507, #661, and #665 7. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 8. A list of continuing education sessions or activities participated in by PNMT members since last review (10/2012) 9. Minutes, including documentation of attendance, for the PNMT and Physical and Nutritional Management Committee (PNMC) meetings for the past 6 months 10. Individual PNMT reports as available for individuals reviewed above 11. A list of PNM assessments and updates completed in the last quarter 12. Individual Support Plans (ISPs) for all sample individuals 13. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 14. Tools used to monitor implementation of PNM procedures and plans 15. A list of individuals for whom PNM monitoring tools were completed in the last quarter 16. Tools utilized for validation of PNM monitoring 17. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans 18. PNMP template and any instructions for use of template 19. PNM spreadsheets generated by the Facility 20. Lists of individuals: a. On modified diets/thickened liquids; b. With BMI equal to greater than 30; c. With BMI equal to less than 20; d. Since October 2012, who have had unplanned weight loss of 10% or greater over six (6) months;

	e. During the past six months, have had a choking incident; f. During the past six months, have had a pneumonia incident; g. During the past six months, have had skin breakdown; h. During the past six months, have had a fall; i. During the past six months, have had a fecal impaction; j. Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); k. With poor oral hygiene; and l. Who receive nutrition through non-oral methods 21. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 22. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 23. Tools and checklists used to provide competency-based training addressing: a. Foundational skills in PNM; and b. Individual PNM and Dining Plans 24. Physical and Nutritional Management Related Training Data **People Interviewed:** 1. Donna Groves OTR Director of Habilitation Therapies 2. Becky Nurre CCC-SLP Speech Director 3. Paula Horn PT 4. Eight DSPs (Cedar Falls, Eastfield, Timberhill and Garden Ridge) **Meeting Attended/Observations:** 1. Physical and Nutritional Management Team 7/23/13 2. Physical and Nutritional Management Committee 7/25/13 3. Mealtimes and Transitions- Garden Ridge, Cedar Falls, Timberhill, and Eastfield
	Facility Self-Assessment: DSSLC's Self-Assessment, updated 7/8/13, 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 not consistent with the Monitoring Team's findings of substantial compliance with Section O.1. For the self-assessment, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the facility self-assessment process. Indicators used to assess specific areas (e.g., assessments) were clearly identified and measurable. Overall, the Action Plans dated 6/21/13 included relevant actions that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report.

	The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools: (i.e., OTs, PTs, and SLPs); therefore there was no evidence that staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. Not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Section O.1 did not include components of the PNM policy). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. The Actions plans developed were felt to move DSSLC in the right direction towards compliance, however, DSSLC should continue to review the findings of the Monitor's report and revise the Action Plans as indicated to address all identified concerns. Overall, the Facility had demonstrated excellent use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed and ensuring the metrics reviewed are aligned with those identified in the Settlement Agreement.
	Summary of Monitor's Assessment: Many positives were noted within this Section. DSSLC continued to take steps forward with regards to 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 improved considerably and were noted to have become more comprehensive and provided staff with detailed strategies to mitigate associated PNM risks. New Employee training was comprehensive and DSSLC provided annual or refresher trainings that focused on preventing aspiration and providing proper transfer and lifting. There was still not a clear consistent process in place to ensure staff were provided with individual specific training prior to working with those individuals who were at an increased risk. **Provision O.1:** This provision was determined to be in substantial 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 PNMT 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 among 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. The PNMC provided a detailed review of clinical indicators with a special emphasis on the root cause of Pneumonia. Among the clinical indicators reviewed by the PNMC on a monthly basis were: Hospitalizations, ER visits, Deaths, Skin Integrity, Enteral Nutrition, Aspiration Pneumonia, and Pneumonia 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. Missing from the policy included requirements for continuing education for PNMT members, evaluation process for individuals who are enterally fed, collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia, and revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor. That being stated, many of components were observed in practice during the course of the compliance visit. All PNMT and PNMC members were qualified and consistently attended the meetings and received ample continuing education needed to remain current in their fields of practice. **Provision O.2:** This provision was determined to be not in compliance. The risk process continued to improve in its ability to identify those individuals who are at increased risk. PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the meeting. **Provision O.3:** This provision was determined to not be in compliance. PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers. Concerning to the Monitoring Team was the lack of an effective system that ensured consistency of the PNMPs across the various locations (i.e., MARs and "Me" books) and the appearance that the strategies contained within the dining plans/PNMPs were becoming less descriptive since previous visits. **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. **Provision O.5:** This provision was determined to be not in compliance. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. **Provision O.6:** This provision was determined to be not in compliance. DSSLC 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. DSSLC did not have a system in place in which information regarding the completion of monitoring forms and its related data could be pulled, analyzed and trended and therefore the Monitoring Team was unable to determine if monitoring covered all areas that were likely to provoke swallowing difficulties or increase PNM risk or if the monitoring occurred across all three shifts. **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 concerns. Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem. There was limited evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status as well as limited to no monthly review by the QDDP. **Provision O.8:** This provision was determined to be not in compliance. 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. Pathways to oral intake focused primarily on pleasure feedings and did not address the benefits of improved oral musculature.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of 12 individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of ten individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of 10 individuals at DSSLC who received enteral nutrition. Some of these individuals might have been included in one of the other samples. Sample O.4 consisted of a review of 24 individuals' PNMPs and Dining Plans located in the MAR and "Me" books. Sample O.5 consisted of 20 individuals observed in homes and day programs throughout the 24-hour	Substantial Compliance

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	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	day. This included random individual-specific observations as well as 20% of the individuals in Sample O.2. This provision was determined to be in substantial 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. 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. The PNMC provided a detailed review of clinical indicators with a special emphasis on the root cause of Pneumonia. Among the clinical indicators reviewed by the PNMC on a monthly basis were: Hospitalizations, ER visits, Deaths, Skin Integrity, Enteral Nutrition, Aspiration Pneumonia, and Pneumonia 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. Missing from the policy included requirements for continuing education for PNMT members, evaluation process for individuals who are enterally fed, collaboration with the Dental Department to address the risk of aspiration during and after dental appointments including after the use of general anesthesia, and revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor. That being stated, many of components were observed in practice during the course of the compliance visit. All PNMT and PNMC members were qualified and consistently attended the meetings and received ample continuing education needed to remain current in their fields of practice. It should be noted that areas regarding a comprehensive PNMP, and proper development and review by IDT, are included in Provisions O.2 and O.3 and therefore were not included in this provision. **PNM Policy and Role of the PNMT:** While the Facility did not have evidence of a comprehensive PNM Policy, many of the areas that were not addressed in policy were in practice and occurring on a consistent basis. It was recommended that the	

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	management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	policy include the following elements: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting	

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		outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. Examples of indicators that were absent included: ▪ Requirements for continuing education for PNMT members. Although this was not listed in policy, upon review of the continuing education received, it was determined by the Monitoring Team that continuing education was at an appropriate level of frequency and included appropriate content for the PNMT. ▪ Method for establishing triggers/thresholds and their integration into the IHCP. Though not in policy, this process was noted through documentation review and via observation of the PNMT meeting on 7/23/13. ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; There was, however, a process in place that improved collaboration with Dental to review the oral care portions of the PNMP. ▪ Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor. The policy stated that the Habilitation Director will provide inter-rater reliability of assessments but did not provide the schedule or did it address reviews of the monitoring process. Although this provision has been found in substantial compliance, the Monitoring Team recommends that these components be developed and included as part of the overall facility policy to ensure consistent and comprehensive implementation **<u>Core PNMT Membership</u>:** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate discipline membership as defined in the Settlement Agreement. DSSLC had identified the Registered Nurse (RN), Physical Therapist (PT), Speech Language Pathologist (SLP), Occupational	

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		Therapist (OT), as standing core members with back-up members identified for RD, RN, OT, and PT. **Consultation with Medical Providers and IDT Members** For twelve of twelve individuals in Sample O.2 (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. For twelve of twelve individuals in Sample O.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. The PNMT was a joint meeting with the IDT; therefore, IDT members for the individuals discussed were consistently involved in the meetings. **Qualifications of PNMT Members** Seventeen of 17 core and back up PNMT members (100%) were licensed to practice in the state of Texas. Seventeen of 17 PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. **Continuing Education** Seventeen of 17 PNMT staff (100%) had completed continuing education directly related to physical and nutritional supports and/or topics transferrable to the population served within the past 12 months. Examples of continuing education included but were not limited to: ▪ PT attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities ▪ SLP attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities ▪ OT attended: Pathway to Intake Advancement ▪ RD attended: Functional Oral Motor Assessment: Making the Connection ▪ RN attended: Triggers and Thresholds **PNMT Meetings** From 10/1/12 to 6/3/13, of the 36 weeks, the PNMT met 35 of 36 weeks at a minimum of once weekly (97%) with most weeks meeting more than once. All core members of the PNMT were present for at least 80% of the meetings with the exception of the RD who was present 77% of the meetings. When paired with their back up, attendance figures for all PNMT members were in excess of 95%. Although the level of participation of the RD was below ideal levels, there appeared to be no adverse outcomes noted as a result.	

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		Fourteen of the 14 PNMT meeting minutes reviewed (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The Facility PNMC did have a sustainable system fully implemented for resolution of systemic issues/concerns. The PNMC met a minimum of monthly. The purpose of the PNMC was to: 1. Identify systemic PNM and clinical issues through: a. Review of facility data related to PNM b. Reports from PNMT, IMRT, QA/QI, Medical, Dental, and nursing committees 2. Develop action plans to address systemic PNM and clinical issues 3. Monitor/review data to determine effectiveness of action plans Per review of the PNMC minutes from 3/31/13 to 5/23/13 there was evidence that the PNMC reviewed systemic issues at DSSLC. Among the issues discussed included: • Fall prevention • Occurrence of pneumonia • Other issues related to dysphagia, oral hygiene, skin integrity and catheter use. As a result of the systemic reviews, additional training and oversight was provided in response to aspiration pneumonias. Per the HT Director, the additional oversight has resulted in increased knowledge of PNM related issues. The Monitoring Team confirmed this during discussion with staff regarding PNMPs. Members of the PNMC included: • Facility Director-Nancy Condon • Assistant Director of Programs-Dora Tillis • Medical Director-Dr. Stephen Kubala • Habilitation Therapies Director-Donna Groves • Chief Nurse Executive-Delia Schilder • Nurse Operations Officer-Sherri Courtney • RN Case Manager Supervisor-Sibylle Graviett • PNMT Occupational Therapist-Jean Myketlyn • QA Director-Lori Powell PNMC attendance was satisfactory as all members of the PNMC had an attendance record of greater than 85%. 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 were:	

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		• Hospitalizations • ER visits • Deaths • Skin Integrity • Enteral Nutrition • Aspiration Pneumonia • Pneumonia • Falls • Diabetes Management Report • Individuals followed by PNMT and the PNMT's level of involvement • UTIs • Pseudomonas The PNMC meeting attended on 7/25/13 contained active conversation by all members of the committee. Trends were analyzed and action plans were developed to either address the issue or investigate further into the root cause of the identified concern. An example of the component of the action plan was to slowly increase the rate of enteral nutrition in an effort to increase tolerance and work towards potential oral intake. Other areas reviewed upon request included but were not limited to: • Enteral Nutrition • Mobility Status • People receiving Botox injections	
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	**Identification of PNM risk** Four hundred and eighteen of 424 individuals (98%) who cannot feed themselves, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The six individuals who did not have PNMPs only needed dining plans and were provided with such. Therefore 100% of individuals with PNM related issues were provided with the appropriate plans of care (PNMP and/or Dining Plan) The Facility had a sustainable system to maintain and update lists of 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"). DSSLC had shown great improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM.	Noncompliance

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	difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	Twelve of 12 individuals in Sample O.1 (100%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). **Physical and Nutritional Management Team Referral Process** Twelve of twelve individuals from Sample O.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. The facility policy stated that at a minimum, the PNMT RN would assess individuals diagnosed with: • Aspiration Pneumonia • Recurrent Pneumonia • GI Issues • Fractures • Skin Integrity Issues • Seizures The PNMT would always review: • Initial or proposed enteral tube placements • Aspiration Pneumonias • Choking incidents requiring physical intervention • Significant unplanned weight loss • Recurrent Pneumonia • Fractures of long bone, skull or hip • Unresolved vomiting • Delayed healing of Stage 2 or Stage 3 or 4 decubitus In ten of the ten individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT or discussion by the PNMT within five working days of the ISPA meeting and/or PNM incident. DSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Based on these discussions, if PNMT involvement was felt to be needed then the IDT was contacted so that a joint meeting would occur to discuss the findings of the assessment, concerns of the PNMT, and how the PNMT could support the IDT by providing a focused or full assessment or by merely discussing the issue and providing guidance to the individual's IDT. As a result, initiation and receipt of the referral occurred simultaneously and was within five working days. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT members in the IRT, IMRT and Integrated Morning Report meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so.	

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		There was not a QA component to the PNMT but as stated earlier in Provision O.1, this component was addressed by the Physical and Nutritional Management Committee (PNMC). Reviewing and identifying trends and the root cause of these trends will allow the sharing of information with the PNMT to facilitate the streamlining and pinpointing of trainings and/or assessments in an effort to prevent future occurrences, as well as identify other improvements and corrective actions that should be addressed. Two of two individuals from Sample O.1 who received a feeding tube (not on an emergency basis) since the last review (100%) had been referred to or discussed by the PNMT prior to the placement of the tube. No individuals at DSSLC received an emergency feeding tube placement since the last review. **PNMT Assessment** Ten of 10 PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). DSSLC's PNMT RN provides assessment upon return from the hospital in an effort to identify any concerns noted with PNM. Results of the assessment were discussed at the PNMT at the weekly meeting or sooner as indicated. Referrals that were submitted by the IDT outside of a return from hospitalization were discussed at the following PNMT weekly meeting with members of the PNMT attending the IDT as indicated. An example of this was for Individual #228 who not seen for a formal PNMT evaluation but was seen jointly by the IDT and members of the PNMT. Ten of 10 PNMT assessments in Sample O.2 (100%) were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. The need for full comprehensive assessments was based upon discussion of the incident and assessment of the situations surrounding the PNM event. Per interview with the Director of Habilitation Therapies, based on the findings and results of discussion, the PNMT then makes the determination of whether a comprehensive assessment was needed. When a full assessment was not warranted, all relevant assessments (i.e., Nutritional, Habilitation) were reviewed for relevance and included as part of the PNMT discussion and taken into consideration when meeting with the IDT. All of these areas in addition to the PNMT RN assessment were taken into consideration when measuring compliance with this metric. The concern with this process was that there was limited to no evidence/documentation that the areas of the PNMT evaluation that were not re-assessed were included as part of the consult/review although it was stated that this occurred. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends that the ISPA demonstrate appropriate documentation to ensure that all areas that may have been impacted by the event or potentially led to the event are clearly discussed and are	

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		documented in the minutes. Based on review of individuals' records who were referred to the PNMT (Sample 0.2), the comprehensiveness of the PNMT assessment components were as follows: • Ten of 10 (100%) contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment. • Ten of 10 (100%) contained date assessment was initiated. This information was contained within the PNMT assessment, PNMT minutes, or Habilitation Therapies Assessments. • Ten of 10 (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment. • Ten of 10 (100%) identified the individual's current risk rating(s), including the current rationale. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Ten of ten (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. This information was contained within the IRRF, ISPA, Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Four of 10 (40%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. • Ten of 10 (100%) contained assessment of current physical status. This information was contained within the PNMT minutes, the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Ten of 10 (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Ten of 10 (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Ten of 10 (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Ten of 10 (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. Two comprehensive Head of Bed (HOB) assessments were provided as part of the PNMT referrals/reviews and all other referrals reviewed contained evidence of evaluation of general posture as part of the Habilitation Assessment, and PNMT RN Assessment. • Ten of 10 (100%) contained evaluation of current adaptive equipment. This information was contained within the Habilitation Assessment as well as the PNMT minutes. • Ten of 10 (100%) contained nutritional assessment, including but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule. This information was contained within the Annual Nutritional Assessment, the PNMT RN Assessment, as well as consults. • Four of ten (40%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. This information was contained within the Nutritional Assessment as well, but	

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		there was no evidence of review of this component evident if there was not a formal PNMT evaluation. • Four of seven (57%) who received enteral nutrition had identified residual thresholds, for return to the PNMT. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting and evaluation. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting. • Four of 10 (40%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting. • Ten of 10 (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Four of ten (40%) contained evidence of review/analysis of lab work. If there was not a formal PNMT evaluation then this area was not discussed as part of the IDT meeting. • Four of 10 (40%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component when there was not a formal PNMT referral and evaluation. • Ten of 10 (100%) contained discussion as to whether existing supports were effective or appropriate. This information was contained within the PNMT RN Assessment, ISPA as well as in the PNMT minutes. • Four of 10 (40%) contained oral hygiene status. This information was contained within the Habilitation Assessment but there was no evidence of review of this component if there was not a formal PNMT referral and evaluation. • Ten of 10 (100%) contained evidence of observation of the individuals' supports at their home and day/work programs. • Ten of 10 (100%) contained evidence that the PNMT conducted hands-on assessment and/or review. • Ten of 10 (100%) identified the potential causes of the individual's physical and nutritional management problems. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Ten of 10 (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Ten of 10 (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. This information was contained as part of the PNMT Assessment, IRRF, PNMT minutes and ISPA. • Ten of 10 (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This information was contained within the Habilitation Assessment as well as part of the PNMT Assessment and PNMT	

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		minutes. • Nine of 10 (90%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP). o Individual #565 had recommendations for a Modified Barium Swallow Study (MBSS) dated 4/9/13 but as of this compliance review, the MBSS had not been completed. • Ten of 10 (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT/IDT. • Four of 4 (100%) contained signatures with dates. Overall, the concern noted was that there was little evidence of the IDT discussing all relevant factors that could be impacted by the significant change if there was not a formal PNMT evaluation. **Integration of PNMT Recommendations into IHCPs and/or ISPs** For two of ten individuals (20%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. Examples of recommendations not integrated included: • Individual #218 had a recommendation to increase Pancreaze to daily but this was not evident in the IHCP or reflected in the ISPA. • Individual #42 had a threshold established of weight loss greater than 5% to be referred to the PNMT but this was not noted as part of the Weight IHCP. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In four of the four individuals' plans reviewed (100%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • In two of the two individuals (100%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. • In four of the 10 individuals' plans reviewed (40%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In four of the 10 individuals' plans reviewed (40%), the plans included the specific clinical indicators of health status to be monitored. • In zero of the 10 individuals' plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Although indicators had been listed for some, objectives were not established. • In 10 of the 10 individuals' plans reviewed (100%), the plans defined triggers. • In zero of the 10 individuals' plans reviewed (0%), the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation for Individuals in Sample O.2: • In ten of ten individuals' documentation reviewed (100%), supporting documentation was	

#	Provision	Assessment of Status	Compliance
		present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • In two of 10 individuals' plans reviewed (20%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. The issue noted was that once the action plan was handed down to the IDT, the tracking of steps to ensure completion was not evident. For example: The PNMT recommended that Individual #492 receive a mobility assessment as well as testing for H Pylori. There was no evidence of IDT follow up to ensure completion. • In order for the Facility to move toward substantial compliance, the Monitoring Team recommends the IDT identify clear due dates for consults and meet in a timely manner upon completion of the task to review the overall plan of care and make any revisions based upon the findings of the consult. **Individuals Discharged from the PNMT** For individuals discharged by the PNMT in Sample O.2: ▪ Four of four individuals (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Four of four individuals' (100%) discharge summaries/action plans provided objective clinical data to justify the discharge. ▪ Zero of four individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ Zero of four individuals' ISPA documentation and/or action plan (0%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. There was not a clear, consistent process that documented a collaborative discharge summary/action plan which included recommended supports and services, key clinical indicators, individualized triggers, guidelines for monitoring the individual's supports, services and triggers, objective clinical data to justify the discharge, evidence that discharge recommendations were integrated into the IHCP, and criteria for referral back to the PNMT integrated as part of the IHCP.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate	**Identification of Individuals Requiring a PNMP** For the twelve individuals in Sample O.1, eleven of their annual ISPs (91%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. Twelve of 12 PNMPs (100%) were reviewed by the individual's IDT in the annual ISP meeting. The ISPs contained evidence of review, update/revision, and effectiveness, and specified the changes required to the PNMP. **PNMP Format and Content**	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 12 of 12 individuals (100%) were current within the last 12 months. • PNMPs for 12 of 12 individuals (100%) included a list of all high-risk levels and individual triggers as indicated. • In 12 of 12 most current PNMPs (100%), there were large and clear color photographs with instructions. • Twelve of 12 PNMPs (100%) listed the adaptive equipment required by the individual. Rationale regarding the need for the adaptive equipment was not present on the PNMP but was available as part of the Habilitation Therapy assessments. • In 12 of 12 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 12 of 12 PNMPs (100%), positioning was adequately described per the individuals' assessments. • In 12 of 12 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 12 of 12 PNMPs (100%), bathing instructions were provided. • In 12 of 12 (100%)PNMPs, toileting-related instructions were provided, including check and change. • In 12 of 12 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning, or the individual was described as independent. • In 12 of 12 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • Twelve of 12 individuals' (100%) Dining Plans were current within the last 12 months. • Eight individuals had feeding tubes with no oral intake. Eight of 8 (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 12 of 12 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In 4 of 4 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 4 of 4 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 4 of 4 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 12 of 12 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 12 of 12 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions.	

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		• Ten of 12 PNMPs (83%) included information related to communication (how individual communicated, how staff should communicate with individual). Missing from the communication section was detailed information on how the person communicated as well as how staff should bridge communication. For example: Individual #66 only stated that the individual makes sounds, smiles and frowns. A concern noted by the Monitoring Team was that strategies related to mealtime are appearing to become less prescriptive and are providing more general directions. This approach is allowable but DSSLC must ensure that the strategies are detailed enough to mitigate the associated risks. **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For 12 individuals in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP, 12 ISPA meeting documentations (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For individuals for whom the PNMP was revised, there was supporting documentation that three of 24 individuals' (Sample O.4) revised PNMPs (12%) had been implemented. Per review of the Medication Administration Records (MARS), Dining Plans, and PNMPs in the "Me" books, there was a pervasive issue with consistency among documents as the vast majority were contained different revision dates and therefore contained different information. For example: Individual #4's plan in his MAR was 2/15/13 while his plan in his "Me" books was revised and dated 7/19/13. Another example was Individual #247's dining plan in the MAR was dated 8/8/11 while his dining plan in the dining room was revised and dated 6/17/13. Failure to have consistent plans results in an increased likelihood of inconsistent care and therefore exposes the individual to unnecessary risk.	
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	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** Staff did not engage in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, three of 20 individuals' (15%) dining plans/PNMPs were implemented as written. Examples of dining plans not implemented included but were not limited to: • Individuals #167, #278, and #665 were observed with their gait belts tightened during the meal resulting in an increased risk of GERD and therefore Aspiration due to abdominal compression. • Individual #79 was observed taking large unsafe bites before having multiple coughing episodes and complaining of stomach pain. • Individual #34 was observed with staff in poor position to assist while receiving bread that was not moistened and using an incorrect cup resulting in an increased risk of choking and/or aspiration. • Individual #398 was not encouraged to take sips of liquids after every 2-3 bites to help clear oral	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
cavity resulting in an increased risk of aspiration and/or choking.

Based on observations by the Monitoring Team:
Zero of 7 individuals' positioning plans (0.5) (0%) were implemented as written. Implementation of positioning plans was extremely concerning as the plans were implemented minimally and the issues noted may have a significant impact as it relates to the risk of skin breakdown, aspiration and pneumonia. Examples of non-implementation included:
• Individual #37 was observed leaning to her left with no side pillows and with her knees compressed against her chest without the knee supports as stated per her PNMP.
• Individual #321 who was at an increased risk of skin breakdown was observed in bed on his right side for two hours when his plan called for him to be repositioned every hour.

Transfers were improved and observations noted:
• Three of three individuals' transfer plans (100%) were implemented as written.

During zero of three observations of medication administration (Sample 0.4) (0%), the nurse followed procedures in the PNMP. As stated in 0.3, the PNMPs in the MARS were outdated and therefore could not be implemented correctly.

The lack of PNMP implementation continued to be a significant concern of the Monitoring Team. Individuals are being placed at an unnecessarily increased risk of harm. Staff did not appear to be aware that they were not implementing the plans and were unaware of the dangers that are being placed on the individuals due to the plans not being implemented as written.

<u>Knowledge of Staff Regarding PNMPs</u>
Staff Interview: Staff were not consistently knowledgeable of the individuals' PNMPs. Based upon interviews with ten staff from Eastfield, Cedar Falls, Timberhill and Garden Ridge, knowledge of staff had continued to improve but was not yet adequate to ensure correct implementation. Following are the numbers of staff who answered correctly and the number asked the question:

<table>
<tr><th></th><th># Asked</th><th># Correct</th><th>% Correct</th></tr>
<tr><td>Positioning:</td><td></td><td></td><td></td></tr>
<tr><td>How do you know the individual is in the correct position in their wheelchair/bed?</td><td>8</td><td>6</td><td>75%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
<tr><td>For what reason does the individual have thickened liquids?</td><td>8</td><td>7</td><td>87%</td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>8</td><td>7</td><td>87%</td></tr>
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		What is the reason for the individual using a specific utensil? — 8 — 5 — 62% If the individual receives enteral nutrition, how do you determine if he/she is in the correct position? — 8 — 5 — 62%	
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.	**NEO Orientation** The PNM related core competencies (i.e., foundational skills) were comprehensive. NEO orientation included the following elements: ▪ Physical Management and Mealtime Training ▪ Lifting People, Transfers and Assistive Equipment ▪ Preventing Aspiration The large majority of staff successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs. Per DSSLC training records, the following percentage of staff had received and successfully passed all NEO trainings. • Lifting People-98% • Physical Management-100% • Preventing Aspiration-97% • Personal Care Services-99% **PNM Core Competencies for Current Staff** Thirty of 30 staff (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. These staff included those who were responsible for training the following courses: ▪ Mealtime ▪ Physical Management ▪ Lifting People ▪ Feeding Practicum with Habilitation Therapies **Annual Refresher Training** As of 6/1/13, staff that require training had completed annual refresher competency-based training and performance check-offs within the last 12 months. ▪ Lifting People: 98% completion rate ▪ Preventing Aspiration: 97% completion rate 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 were "Lifting People" and "Preventing Aspiration." Missing from the annual trainings were Physical Management Skills and Personal Care Services. It was	Noncompliance

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		unclear as to why only "Lifting People" was provided annually when the other areas are equally important in ensuring staff remain updated on latest standards of care. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends the Facility develop shortened versions of the classes (possibly using ilearn) covering all trainings related to PNM. **Individual-Specific Training** To determine whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed four individuals from Sample O.1 and reviewed evidence that staff working with these individuals had received all the training related to PNM. Based on that evidence and interview, the Monitoring Team determined the Facility did not have a clear process in place. The concern noted with the training process was that there was not a clear start date of the training documented; therefore it the Monitoring Team was unable to determine if the training was provided in a timely manner. Another concern was that the Monitoring Team was unable to determine if all shifts had been trained as the staff and their corresponding shift was not provided as part of the training documentation. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends the Facility add a location on the training roster that signifies the staff's shift as well as utilize their data to list staff requiring training on the training roster in an effort to ensure all staff are trained. There was no evidence that Staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. While the name of the staff providing training was included on the form as the trainer, there was no evidence that staff had been trained by the clinician who recommended the strategies and/or revisions. In order for the Facility to move in the direction of substantial compliance, the Monitoring Team recommends the training forms include evidence that the individual providing the training outside of the clinician be listed as receiving the training and there is evidence of completion of all applicable competencies. These could be accomplished by having the trained instructor be listed as the first person trained on the provided roster and identified as the trainer. A process did not exist but was currently being developed by DSSLC that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. 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	

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		change in status. This will be reviewed at the next compliance visit. DSSLC was in the process of developing a three-level system that will categorize individuals into three levels of need and would require different levels of staff training in order to work with the individual. The levels were as follows: • Level 1: These individuals have PNMP information/techniques that are such that, if staff does not respond in exactly the right way, there is a very high risk of serious injury or other serious negative outcome to the person served. These individuals have a PNMP which is so specialized that it incorporates very specific techniques(s) that is not taught and competency assessed in any of the general Habilitation Lifting/.Positioning, PNMP training, or monitoring training. Staff would have to learn and demonstrate additional competencies to implement the PNMP. • Level 2: These individuals have PNMPs that are specialized but use techniques that are taught and competency assessed in the general Habilitation lifting/Positioning, PNMP training and/or monitoring training. Staff need to know which skills to use and may need to have experience using the skills, but would not have to learn new skills to use the plan. Staff would know how to implement by reading the plan and having a chance to ask questions for clarification. • Level 3: These individuals either do not have a PNMP or have a simple PNMP with no specialized instructions. The individual's levels would be initially determined based on consultation by the Director of Habilitation Therapies and other professional staff. After the initial classification, it is recommended that DSSLC identify a meeting such as the IMRT to be the place where individual's levels are determined. The IMRT appears appropriate as all changes in status should be discussed during this time. It is also recommended that whoever is classified as a level 1 has this classification listed on their PNMP. Per the Director of Habilitation Therapies (HT), the Unit will decide which employees require the training needed to provide care for Level 1 individuals in the unit. It is important that although Level 2 individuals may not require the same level of training as Level 1, there remains a need to document the information sharing of the PNMP components for the individual served.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the	**Facility's System for Monitoring of Staff Competency with PNMPs** Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. As stated in previous reports, 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. It should be noted that DSSLC had added a guideline that stated that if implementation was not noted then a score of "Noncompliance" was automatic. However, this was	Noncompliance

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	implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	not consistently noted to occur. An example was the monitoring of Individual #42 in which the plan was not implemented yet the score remained as "Compliance". Other issues included overall inconsistency in how the Universal Monitoring Forms were completed and lack of evidence of training in response to identified issues. Monitoring tools included adequate instructions/guidelines. The State Supported Living Center Compliance Monitoring Form had guiding questions regarding what the staff conducting the monitoring should be considering and looking for, and included how training should be provided in the occurrence a deficiency was noted and how the information would be shared at the Incident Review Team (IRT). DSSLC had recently begun to utilize the PNMP Coordinators (PNMPCs) as Mealtime Coordinators (MTCs) three days week. The role of the MTC was to provide overall direction, monitoring and assistance during mealtimes. All the PNMPCs had received training on the process and expectations. Per the HT Director, a process had not yet been developed to ensure validation of services but plans were developed that would have members of the PNMC observing the MTCs once weekly to ensure job performance. Since the process has not yet been developed, the Monitoring Team will review at the next compliance visit. Twenty-eight of 28 staff (100%) responsible for conducting the monitoring were provided with the training needed to successfully complete the forms in a consistent and comprehensive manner. Although completion of the core training components and level of monitoring would be expected to result in increased implementation, the Monitoring Team's observations did not reflect an improvement in implementation. Issues with implementation are noted above in Provision O.4. As of this review, DSSLC did not have a formal system in place in which information regarding the completion of monitoring forms and its related data could be pulled, analyzed and trended and therefore the Monitoring Team was unable to determine if monitoring covered all areas that were likely to provoke swallowing difficulties or increase PNM risk or if the monitoring occurred across all three shifts. A graph showing the approximate percentage of areas monitored for PNM during the months of October 2012 to May 2013 provided information as follows:	

	Bathing	Lifting/Transfer	Meal	Med Admin	Oral Care	Positioning	Snack	Communication
10/12	≈3%	≈5%	≈21%	≈11%	≈10%	≈25%	≈5%	≈20%
11/12	0%	≈2%	≈22%	≈11%	≈42%	≈14%	≈3%	≈6%
12/12	0%	≈3%	≈20%	≈5%	≈39%	≈25%	0%	≈8%
1/13	0%	≈9%	≈65%	≈0%	≈0%	≈26%	0%	0%
2/13	0%	≈4%	≈63%	≈22%	≈0%	≈11%	0%	0%

#	Provision	Assessment of Status	Compliance

3/13	0%	≈14%	≈57%	≈8%	≈5%	≈11%	0%	≈5%
4/13	0%	≈11%	≈63%	≈2%	≈6%	≈15%	≈3%	0%
5/13	0%	≈11%	≈50%	≈0%	≈0%	≈39%	0%	0%

The above graph demonstrates a disproportionate number of monitors being focused on meals with other areas in which difficulties are likely to be provoked not receiving monitoring at all.

Monitoring for Individuals in Samples

For individuals in Sample O.1 and O.2, the Monitoring Team was unable to determine if PNM compliance monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. The reasoning for the inability was that, as stated above, there was no method for pulling reports that detailed date, activity monitored, and time of monitor. Another reason was that the individual's assessment and/or plans/IHCPs did not specify clearly the level or frequency in which the person should be monitored in response to PNM related events.

The PNM policy (CMGMT 32-rev 6/17/13) stated that individuals with higher risk will be monitored at an increased frequency but provided no specifics regarding the number of monitors that will be completed per risk level. The Universal Monitoring Plan (revised 1/15/13) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. This frequency was set at once per quarter, which was a significant decrease in frequency since the last visit (which was twice monthly for high risk and once quarterly for medium risk). The decrease was a concern, as those individuals who are at medium risk still should receive some level of monitoring outside of the annual assessment and/or review. Per interview with the HT Director, frequency of monitors will be increased to once monthly for High risk and quarterly for Moderate Risk at the end of the year but this had not been put into a process as of this date. Additionally, a method for determining inter-rater reliability had not yet been formalized.

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	**IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans** Zero of the 10 individuals' records (0%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy). Zero of the 12 individuals' records in Samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews only stated if changes were made to the PNMP and provided no information regarding status of the individual or if the individual had any issues related to PNM.	Noncompliance

#	Provision	Assessment of Status	Compliance
	physical or nutritional management difficulties, and revise interventions as appropriate.	Six of 12 individuals' records (50%) in Samples O.1 and O.2 included evidence that the IDT discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. As part of the IRRF, the IDT identified if there was a need to implement a trigger sheet. Zero of 12 Trigger sheets (0%) were completed correctly. Zero of 12 Trigger sheets (0%) were reviewed at a minimum daily by the appropriate shift RN. Issues with the Aspiration Trigger Sheet included: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing and Case Manager Review of the trigger sheet was inconsistent.	
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.	**Evaluation of Individuals who receive Enteral Nutrition** The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. Ten of 10 individuals who receive enteral nutrition (Sample O.3) (100%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, OT/PT Assessment and Nutritional Assessment. Nine of 10 individuals (90%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. Medical necessity was identified as part of the Nutritional Assessment, Habilitation Assessment, IRRF as well as part of the Aspiration Pneumonia and Enteral Nutrition (APEN). One individual who received enteral nourishment was admitted since the last review; and was reviewed to determine the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** Zero of 10 individuals (0%) from Sample O.3 who receive enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. This information was contained within the OT/PT assessment and included as part of the ISP. Although return to oral intake was included as part of the Habilitation Assessment template, there was not a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control.	Noncompliance

#	Provision	Assessment of Status	Compliance
		DSSLC had developed an Oral Motor Intervention Policy and staff (Habilitation Clinicians) had attended a training provided by Deann O'Lennick MS, CCC/SLP, but as of this review and sample drawn there was no evidence that this had been put into practice. Plans for increased oral intake focused primarily on pleasure feedings. DSSLC did not consistently provide treatments or strategies to help move the individual along the pathway to oral intake. Examples included: • Individual #101 and #228 were identified as having poor oral motor ability but no plan was in place to improve oral musculature was recommended. An extended sample was drawn in an effort to review individuals who had received oral motor treatment relevant to dysphagia. At the time of the review, this consisted of only one individual. Zero of one individual from sample O.5 who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (0%) had a comprehensive plan outlining the treatment or return to PO process. Zero of one individual's plans to return to oral eating or improve oral eating was based on the results of the IDT's discussion (0%) and was integrated in the IHCP, ISP, and/or an ISPA. While it was based on IDT discussion, there was no evidence of integration into the IHCP. Zero of one individual's plans to return to oral eating in the IHCP (0%) were implemented in a timely manner. Individual #606 was scheduled to begin treatment by 7/15/13 but had not received treatment as of this review. Based on review of the individual in Sample O.5, the plan did not include the following components: • Staff roles and responsibilities (e.g., implementation, monitoring); • Time and schedule of interventions; • Specific triggers for when the plan should be stopped; • Milestones for progressing with the plan; • Documentation requirements (method for tracking progress); and • Frequency of subsequent assessments and staff responsible. Ten of the ten individuals' plans (discussions) regarding return to oral eating were based on the results of the IDT's discussion (100%) and were integrated in the IHCP, ISP, and/or an ISPA. But as stated previously, this discussion primarily focused on whether the individual would benefit from pleasure feedings and did not contain discussion of oral motor treatment.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** 1. DSSLC Self Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 3. Presentation Book for Section I, Section O, and Section P 4. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 6/17/13) 5. Universal Monitoring Plan rev: 1/15/13 6. Record reviews: • Sample P.1: Individuals #42, #66, #92, #101, #211, #218, #228, #463, #492, #499, #565, #739 • Sample P.2: Individuals #37, #83, #86, #126, #271, #422, #432, #462, #689, #758 7. 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 8. A list of continuing education sessions or activities participated in by PNMT members since last review (10/2012) 9. Current Lists of people: (a) Who use wheelchair as primary mobility; (b) With transport wheelchairs; (c) With other ambulation assistive devices, including the name of the device; (d) With orthotics and/or braces; (e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution; (f) Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury. 8. Wheelchair Repair Log (December 2012) 9. OT/PT assessments template and guidelines 10. For the past 6 months, any summary reports or analyses of monitoring results related to OT/PT generated by the Facility, including but not limited to quality assurance reports, including action plans. 11. List of individuals receiving direct OT and/or PT services and focus of intervention. 12. List of ten individuals with the most falls since the last compliance review **People Interviewed:** 1. Donna Groves OTR Director of Habilitation Therapies 2. Paula Horn PT 3. Cecilia Payne COTA PNMP Coordinator 4. Eight DCPs (Timberhill, Cedar Falls, Eastfield, Garden Ridge) **Meeting Attended/Observations:** 1. Physical and Nutritional Management Team 7/23/14 2. Physical and Nutritional Management Committee 7/25/13 3. Mealtimes and Transitions- Timberhill, Cedar Falls, Garden Ridge, and Eastfield

	Facility Self-Assessment: For Section P in conducting its self-assessment: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P. o This monitoring/audit tool did not include adequate indicators 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: Provision P.2 in the Self-Assessment did not include implementation of direct intervention plans as well as comprehensiveness of treatment notes. o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools, i.e., OTs, PTs, and SLPs; therefore there was no evidence that staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. . ▪ The Facility rated itself as not being in compliance in all the provisions of Section P (Provisions P.1 through P.4). This was consistent with the Monitoring Team's findings. The Actions plans developed were felt to move DSSLC in the right direction towards compliance; however, DSSLC should continue to review the findings of the Monitor's report and revise the Action Plan as indicated to address all identified concerns.
	Summary of Monitor's Assessment: DSSLC continued to show overall improvement with services identified within this provision. While still requiring additional work, the assessments continued to improve and provided a more comprehensive review of the individual. Indirect Supports (i.e., PNMPs) showed significant improvement and did an admirable job in outlining the supports needing to be implemented by staff to mitigate risk. **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 comprehensive as they lacked objective measurements and detailed information that allowed for comparative annual analysis. Additional concerns noted in the assessment reports reviewed included: • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In 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. **Provision P.2:** This provision was determined to be not in compliance. Therapy services were not

	consistently integrated into the ISP. Direct Services were not consistently documented and did not provide comprehensive documentation regarding benefit of services as well discharge information sharing with the IDT. **Provision P.3:** This provision was determined to be not in compliance. There was no process in place to ensure OT/PT supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. **Provision P.4:** This provision was determined to be not in compliance. A formal monitoring system did not exist for the adequate monitoring of OT/PT supports.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional 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.	Samples for this section were as follows: Sample P.1 is the same as Sample O.1 that consisted of a non-random sample of 12 individuals who were chosen from a list provided by the facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Sample P.2 consisted of 10 individuals who receive direct OT/PT services that is chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy. **<u>Timeliness of Assessments</u>** Sixteen of 16 admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Sixteen of 16 individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of admission. DSSLC does not do screening upon admission but, instead, conducts a comprehensive OT/PT assessment. The Monitoring Team considers the presence of assessments as meeting and surpassing compliance with this metric. Twenty of 22 individuals' OT/PT assessments in sample P.1 and P.2 (91%) were dated as having been completed at least 10 days prior to the annual ISP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Twenty-two of 22 assessments or updates in Sample P.1 and P.2 (100%) were current within 12 months for individuals who are provided PNM supports and services. **<u>OT/PT Assessment</u>** Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments for Samples P.1 and P.2 were as follows: • Twenty of 22 individuals' OT/PT assessments (90%) were signed and dated by the clinician upon completion of the written report. • Sixteen of 22 assessments (72%) included diagnoses and relevance to functional status. • Fifteen of 22 assessments (68%) included a section that reported health risk levels that were associated with PNM supports and how it impacts the individuals. • Two of 22 assessments (9%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • One of 22 individuals' OT/PT assessments (4%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Ten of 22 assessments (45%) included medical history and relevance to functional status. • Nineteen of 22 assessments (86%) addressed health status over the last year • Five of 22 assessments (22%) listed medications and potential side effects relevant to functional status. • Four of 22 assessments (18%) included documentation of how the individual's risk levels impact their performance of functional skills. • Twenty-two of 22 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). • Seventeen of 22 assessments (77%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. • Ten of 22 assessments (45%) included discussion of the expansion of the individual's current abilities. • Three of 22 assessments (13%) included discussion of the individual's potential to develop new functional skills. • Twenty-one of 22 assessments (95%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day.	

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		• Twenty-two of 22 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. • Zero of 22 assessments (0%) included evidence of the Individual's monitoring schedule. A monitoring schedule based on risk existed but was not referenced as part of the assessment as being appropriate to meet the needs of the Individual. • Zero of 22 assessments (0%) included a re-assessment schedule. The reassessment schedule was an updated every year if receiving direct or indirect services and a comprehensive every three years for everyone. • Twenty-two of 22 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. • Twenty-two of 22 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Twenty-two of 22 assessments (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature and/or documentation within the assessment. • Twenty-two of 22 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement." • Twenty-two of 22 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP.	
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	**OT/PT Interventions** For individuals receiving OT/PT supports and services, 22 of 22 plans for Samples P.1 and P.2 (100%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. For 22 of 22 individuals in Samples P.1 and P.2 (100%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Primary integration was in the form of discussion and review of the PNMP. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed resulting in the following	Noncompliance

#	Provision	Assessment of Status	Compliance
	include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	findings: • Ten of ten individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For two of ten individuals' records (20%) reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • For zero of ten individuals' records (0%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT plan of service. • For zero of seven individuals' records (0%), whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Clinical justification for the termination of a direct intervention plan was not consistently included as part of the discharge/final note. Another problem identified was that there was no consistent ISPA meeting upon discharge to discuss final results and recommendations. **<u>Indirect OT/PT Programs</u>** The implementation of these plans is discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. **<u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u>** An OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Twenty-one of 22 ISP annual meetings (95%) had a member from either OT or PT present to represent the disciplines. Twenty-two of 22 ISPs or ISPAs from Samples P.1 and P.2 (100%) integrated the OT/PT interventions. The ISP or ISPA consistently described the supports based on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. Skill acquisition programs were not recommended in the OT/PT assessments; therefore, the Monitoring Team was unable to determine if these were integrated. While the OT/PT assessment did not consistently identify ADL skill acquisition, it was noted that the ISPs had significantly improved as it related to identify goals/objectives	

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		to address the improvement of ADL skills. One of ten individuals receiving direct OT/PT Services (Sample P.2) (10%) were provided with comprehensive progress notes (IPNs) that contained all of the indicators listed below. Progress notes included the following indicators: • Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). • Reported the consistency of implementation. • Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. Progress notes did not consistently include the following indicators: • Described the benefit of the goal to the individual. Although this indicator was not present as part of every notes entry, it was observed as part of the initial as well as discharge/final note and therefore meets the intent of this indicator. • A comprehensive progress note was completed on at least a monthly basis. For example: Individual #462 did not have progress notes from 1/17/13 to 3/8/13. For individuals with PNMPs or SAPs, for 0 of 22 individuals in Samples P.1 and P.2 (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from the OT and PT and/or QDDP did not include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. The monthly QDDP note simply stated that service was provided or that there were no changes to the PNMP. No more detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review.	
P3	Commencing within six months of the Effective Date hereof and with	The requirements for this section were discussed in detail with regard to Section O.5. Indirect plans are inclusive of the PNMPs since OT/PT is covered substantially in the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	PNMP.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**<u>Monitoring System</u>** The Facility did not implement a system for the adequate monitoring of PNMPs. • See Provision O.6 The Universal Monitoring Plan (revised 1/15/13) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. This frequency was set at once per quarter, which was a significant decrease in frequency since the last visit (which was twice monthly for high risk and once quarterly for medium risk). The decrease was a concern, as those individuals who are at medium risk still should receive some level of monitoring outside of the annual assessment and/or review. Per interview with the HT Director, frequency of monitors will be increased to once monthly for High risk and quarterly for Moderate Risk at the end of the year but this had not been put into a formal agreed upon process as of this date. Additionally, a method for determining inter-rater reliability had not yet been formalized. The Facility did not have a comprehensive OT/PT policy. The policy included the following elements: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identifies the frequency of assessments; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services Missing from policies/procedures reviewed were elements that:	Noncompliance

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		• Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; These areas are related to issues noted earlier in Section P regarding lack of monthly review of services. For 22 of 22 individuals (100%), routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Monitoring data logs provided to the Monitoring Team indicated checks of positioning devices and other adaptive equipment were included as part of the risk based PNMP monitoring as well as preventative checks by the wheelchair clinic. For 21 of 22 individuals (95%), positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per review of the Wheelchair Repair Log, 17 of 17 individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (100%), equipment was repaired or replaced within 30 days unless justification is provided, or unless the issue impacts the individual's health or safety, then action was taken within 48 hours.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/2013 2. DSSLC Action Plan 6/ 21/2013 3. DSSLC Presentation Book, Section Q (undated) 4. Presentation Book for Section Q 5. DSSLC Dental Policy for Dental Emergencies - dental services Overview DS-09, dated 12/11/2012 6. DSSLC Dental Care – Suction Toothbrushing Protocol DS-04; 04/23/2013 7. List of all dental staff, along with their professional title, and indication if they were full or part time, and the number of hours they provide direct care services. 8. List of continuing education opportunities obtained by dental office staff 9. Annual dental assessments, most recent Individual Support Plans (ISPs), Integrated Risk Rating Forms (IRRFs), and Physical and Nutritional Management Plans (PNMPs) for Individuals #228, #427, #167, #242, #583, #549, 766, #289, #457, and #5 10. The most recent annual dental assessments, PNMPs, IRRFs, for Individuals #170, #367, #474, #163, #416, #580, #335, #581, #697, and #520 11. The most recent annual dental assessment, dental notes, IPNs and ISPs, specific to the most recent dental emergency for Individuals #791, #409, #605, #250, #91, #413, #565, #783, #79, and #707 12. List of all dental emergencies that occurred during the past six months 13. Copy of dental schedule for past, and future six-month period 14. List of all individuals who received pre-treatment oral sedation during the past six months, and for the first ten individuals on the list: dental notes, IPNs, post sedation monitoring tools, and ISP associated with the administration and monitoring of pre-treatment oral sedation for dental services 15. List of individuals who required TIVA during the past six months 16. Anesthesia monitoring forms, IPNs, and dental records, specific for monitoring TIVA for Individuals #204, #699, #391, #661, and #472 **People Interviewed:** 1. Dr. Paul Nelson, DDS, Dental Director **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Facility provided a self-assessment for Provision Q.1 and Q.2. Also noted in the presentation book was an assessment tool entitled Denton State Supported Living Center Quality Assurance Review. The assessment tool evaluated dates of dental examinations, and assessments, and determination if various assessments were provided, but did not cover all of the issues assessed within the self-assessment. For example, the self-assessment rated the Facility as having documented the screening for oral cancer in 94% of the cases reviewed, and that 100% of the cases reviewed noted that dental x-rays were current; however, the quality assurance review form did not assess for these, and many other issues assessed. The self-assessment identified many important issues, relevant to the Settlement Agreement (SA), such as

	assessing for oral cancer assessment, use of radiograph, timely completion of dental assessment, follow-up to dental emergencies, post sedation monitoring following TIVA, and consistency among dental IPNs, and DPNs. The Monitoring Team was very impressed with the Facility's assessment of individuals who developed pneumonia following a dental visit. The Monitoring Team believes that the Facility has identified many appropriate indicators but does not believe that the assessment of the indicators is adequate. The assessment mostly addressed process, and not quality. For example, the Facility rated 16% of the individuals as having poor oral hygiene, 41% having fair oral hygiene, and 43% having good oral hygiene. While this data reflects what was reported on the annual dental assessments, it did not assess the clinical correlation between the actual oral health examination, and the determination of the oral health rating. The Monitoring Team had significant concerns that oral health care rating of poor, fair and good, did not accurately reflect the actual findings of the oral health assessment, because many individuals with bleeding gums, moderate periodontal disease, and moderate plaque, were assessed as having fair or good oral hygiene ratings. Another example is that the self-assessment rated 100% of the PNMPs having incorporated dental positioning, and while this may be correct, there was no assessment to evaluate if the PNMP positioning was actually appropriate for the individual's needs. Also, the Facility did not assess to see if all relevant oral health issues, as delineated on the IRRF, and annual dental summary, were incorporated on the PNMPs. The Monitoring Team suggests a self-assessment be developed to evaluate the quality of issues being assessed. The Facility's action plan was extremely limited by mostly only addressing training issues, and the dental database. The action plan should be more specific, and identify all necessary actions to become compliant with the Provision. The Facility determined that is was not in compliance with either provision of Section Q, for the Settlement agreement, and the Monitoring Team concurred with the Facility.
	Summary of Monitor's Assessment: The Monitoring Team compliments the Facility for its continued and significant improvements observed with dental services. The Facility has made significant strides with documenting practices, timeliness of annual assessments, providing emergency dental services, monitoring of individuals undergoing sedation, and enhancing the IRRF, and PNMP process. Compliance, however, will require further improvements. Specific comments and concerns for each section are as follows: Provision Q.1: In general, the overall quality of routine and emergency dental services has significantly improved, as individuals are assessed and provided treatment timely and effectively. Compliance will require further improvements by ensuring consistency with recommendations made on the PNMPs, IRRFs, and dental summaries; enhance the process for assessing the needs for various oral health care services, such as suction toothbrushing; and better standardize the rating scale for oral hygiene. The dental office must ensure that an oral health care treatment plan is developed for the CLDP, and that oral health care indicators are monitoring, during the post move monitoring period. Dental services must also be identified, prior to the transfer of an individual.

	Provision Q2: The Monitoring Team is extremely impressed with the Facility's improvements in the areas of reducing missed dental appointments, and close monitoring at the infirmary of individuals who received dental services under anesthesia and oral sedation. There has been noted improvements in further enhancing programs to minimize sedations. However, because the Facility's lack of a specific dental quality assurance program, inadequate programs to help minimize the need for sedation, need to improve on assessing the needs of individuals for programs to help minimize the use of sedation, and need to enhance documentation of post sedation monitoring at the living area, and completion of the Facility's specific post sedation monitoring form, the Monitoring Team determined that the Facility is noncompliant with section Q.2.

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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.	To assess the Facility's ability to provided oral health care needs at the Facility, the Monitoring Team assess dental administration; the provision of routine, restorative, and emergency oral health care; dental hygiene; oral hygiene provided by the living area, including the use of suction toothbrushing; and dental imaging <u>Dental Administration</u> The dental office had recently hired a new director of dental services, who oversees the provision of oral health care at the Facility, and the settlement agreements. In addition, the director provides eight hours per week of direct dental care. The Facility also maintains the following staff: • One Full time dentist, who provided 40 hours of direct care • Two dental hygienists, who each provided 40 hours of direct care • Two dental assistants, who provided both administrative support and direct care • One contract anesthesiologist, who provided approximately ten hours of service to the Facility each week Review of continuing education certificates obtained by dentists and dental hygienists indicated that all staff received continuing education for their profession, during the reporting period. In addition to many continuing dental educational venues for general dentistry, the dental director participated in a special needs dental continuing education venue. The Dental director informed the Monitoring Team that the DADS dental database is now fully operational, and they have recently begun entering data. One limitation reported was the need for additional staff time to assist in updating and maintaining necessary data elements.	Noncompliance

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		Suction Toothbrushing To assess the Facility's suction toothbrushing program, the Monitoring Team requested a list of all individuals who were provided suction toothbrushing, and for the first ten individuals on the list, a copy of the most recent oral health care rating scale, copy of the Integrated Service Plan (ISP), and the most recent quality assessment of suction toothbrushing. In addition, the Facility's Dental Care – Suction Toothbrushing Protocol DS-04; 04/23/2013, was reviewed. The Facility maintained a protocol on suction toothbrushing, which described the rationale for the use of suction toothbrushing, and specific technical details of the dental toothbrushing program. However, there was no protocol indicating how often the need for suction toothbrushing should be assessed; no mention of a specific assessment tool to determine the potential future need for suction toothbrushing, following an initial assessment; and no mention of assessing individuals for efficacy and safety for the use of suction toothbrushing. The Facility provided a list that indicated a total of 124 individuals received suction toothbrushing, and for the first ten individuals (Individuals #228, #427, #167, #242, #583, #549, 766, #289, #457, #5), reviewed the most recent oral health care rating scale; and copy of the Integrated Support Plan (ISP), PNMP, and IRRF. • Zero out of ten cases reviewed (0%), included documentation to support that the Facility regularly assessed efficacy of staff's administration of suction toothbrushing. • The Integrated Risk Rating Form (IRRF) indicated the risks associated with suction toothbrushing in zero out of ten cases reviewed (0%). • The IRRF clearly delineated the rationale for the use of suction toothbrushing in zero out of ten cases reviewed (0%). • Physical Nutritional Management Plans (PNMPs) were provided for Individuals #457 and #5, and an Integrated Healthcare Plan (IHCP) was provided for Individual #583. In three out of the three cases, there was no comment about risks, efficacy, and strategies to best assist the individuals when administering suction toothbrushing. The only statement about suction toothbrushing was, for one case, "suction toothbrushing to be provided by staff". The Monitoring Team compliments the Facility for developing a suction toothbrushing program; however, its protocol for suction toothbrushing did not clearly delineate important clinical issues, such as the monitoring of efficacy and safety, and did not indicate how and when individuals would be screened for the use of suction toothbrushing. Also, the Facility did not document essential elements associated with	

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		suction toothbrushing, such as specific indicators for use, risks associated with the use of suction toothbrushing, and mechanisms to overcome challenges associated with suction toothbrushing. Dental Imaging To assess the Facility's ability to provide clinically appropriate dental imaging studies, the Monitoring Team discussed the issue with the dental director, and reviewed the annual dental assessments for Individuals #170, #367, #474, #163, #416, #580, #335, #581, #697, and #520. The date of the most recent set of dental x-rays was clearly documented on the annual dental assessment, in ten out of ten (100%) samples. And in nine out of ten cases (90%), dental imaging studies were obtained within the past 24 months. The dental director informed the Monitoring Team that the Facility currently provides dental x-rays every 24 months, and a panovision x-ray every five years. The dental director commented that he will review current standard of care practice related to dental imaging, and update the Facility's protocol and practice standard to reflect any necessary changes. The Monitoring Team recognizes the clinical variances associated with dental imaging, including potential risks associated with radiation, and challenging behaviors. In general, unless there is documented rationale for not complying with standard of care practice, the Monitoring Team relies upon recommendations per the American Dental Association. The Monitoring Team was impressed with the Facility's plan to implement a Scan-X digital imaging format system, which will greatly enhance compliance, and minimize potential adverse effects secondary to dental imaging. Dental Emergencies To assess dental emergencies, the Monitoring Team requested copies of policies and protocols for dental emergencies; a list of all dental emergencies that occurred during the reporting period, including the individuals' names, description of the dental emergency, and date and time when the dental emergency was first identified. In addition, the following information was requested for the first ten individuals on the list of individuals who had a dental emergency: • Copy of all associated dental progress notes, associated with the dental emergency • ISP minutes documenting the dental emergency • Integrated Progress Notes (IPNs) associated with the dental emergency	

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		The Monitoring Team's review of the Facility's policy for dental emergencies, Dental Policy for Dental Emergencies - dental services Overview DS-09, dated 12/11/2012, indicated it clearly outlined the Facility's protocol on managing dental emergencies. There were 16 reported dental emergencies that occurred during the reporting period. Of the ten individual cases reviewed (Individuals #791, #409, #605, #250, #91, #413, #565, #783, #79, and #707): • In zero out of ten cases (0%), the dental note documented an action plan that included further monitoring parameters, and necessary follow-up for the dental emergency. • In ten out of ten cases (100%), the dental IPN reflected the dental note's assessment and treatment of the dental emergency. • In ten out of ten cases (100%), the dental emergency was provided immediate clinical attention. • In zero out of ten cases (0%), there was evidence to support that the IDT discussed the dental emergency. The Monitoring Team noted that IDT was not actively involved in the follow-up to dental emergencies. For example, Individual #91, sustained a fractured tooth, which should have prompted a review by the IDT; however, there was no evidence to support the IDTs involvement in assessing how the tooth was fractured. The Monitoring Team also noted that several individuals required further evaluation, and treatment under sedation, which resulted in a significant delay in treatment: • Individual #413 required examination under sedation because of behaviors, and the exam did not occur for 13 days. • Individual # 91 was noted to have a fractured tooth (#4), and was to have the remained of the tooth extracted at a later time, under anesthesia; however, the Monitoring Team could not identify, in the records provided, that the treatment was actually completed. The Monitoring Team was pleased to see individuals were promptly evaluated for dental emergencies, and that documentation on the dental progress notes, and IPNs had improved. Substantial compliance will require additional improvement in the following areas: • All necessary dental treatments must be promptly provided. Delay of weeks or longer to complete an evaluation is not an acceptable standard of care practice. • The dental note must be comprehensive, and include the issue leading to the dental emergency, services provided, services pending, challenges with providing necessary services, follow-up plan, and specific instructions for nurses	

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		and DSPs, • The IDT should review all dental emergencies that required treatment. <u>Annual Dental Examinations, Dental Hygiene, and Schedule for Oral Health Care</u> To assess the Facility's ability to provide routine oral healthcare, the Monitoring Team requested a copy of the previous six months, and pending six months, annual dental schedule, and an alpha list of all individuals who had not fully completed their annual dental examination. In addition, the most recent two dental summaries, and associated IPNs, dental hygiene records, and most recent ISP documenting dental issues was requested for the first, and then every fifth individual, on the current name key, for a total of ten case samples. The Monitoring Team was provided a printout copy of the "PSP Conference Calendar" dated February 2013, through July 15, 2013. The PSP conference calendar did not indicate that is was the dental schedule, but had the letter "OH", and the words "Current" and "last", suggesting that the schedule implied dates of the last and current annual dental examination. The Facility provided a list of all individuals who were reported not to have completed their annual dental examination within the scheduled time frame of ten days prior to the annual ISP meeting. Based upon census data for July 15, 2013, of 484individuals residing at the Facility, six out of 484 individuals (1.2%) had not completed their annual dental examination, which is an exceptionally low number of delinquent annual dental examinations. Review of the most recent IPNs, dental progress notes, PNMP, past two annual dental assessments, and dental hygiene records indicated the following: • The most recent annual dental summary was completed within 12 months or less, from the date of the previous annual dental assessment, in ten out of ten (100%) cases. • The most recent annual dental summary was completed prior to the annual ISP meeting, in ten out of ten (100%) cases. • The most recent annual dental assessment evaluated oral hygiene, periodontal disease, plaque, and gum health in nine out of ten (90%) cases. • The most recent annual dental assessment, assessed specific condition of teeth, including caries and tooth movement, in zero out of 10 (0%) samples. • The most recent annual dental assessment documented the level of restraint required to perform dental examinations, and treatments, in ten out of ten (100%) cases. • The most recent PMNP documented oral health care condition, in ten out of ten (100%) cases. • The most recent PMNP accurately reflected special requirements, such as the	

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		use of spin tooth brushes, specific types of toothpaste, mouth rinsing, flossing, and special supports, as delineated on the IRRF, in two out of ten cases (20%). • The most recent IRRF documented oral health care issues, in ten out of ten (100%) cases. • The most recent IRRF accurately documented clinically significant issues, as reported on the annual dental assessment, such as risk factors associated with the use of sedation, and compliance with dental treatments, in two out of ten (20%) cases. • There was an associated IPN for each annual dental assessment in ten out of ten (100%) cases. • The IPN documented the clinical issue, treatment provided, pending treatment, and specific monitoring and reporting parameters, in non-dental language, in zero out of ten (0%) samples. • The annual dental assessment documented when the last dental x-rays were obtained, in ten out of ten (100%) samples. • The most recent annual dental summary included a comment about oral cancer screening in zero out of ten (0%) cases. The following is a summary of concerns identified following review of the IPNs, annual dental summary, IRRFs, and PMNPs, for Individuals #170, #367, #474, #163, #416, #580, #335, #581, #697, #520. Individual #170 The PNMP, dated 7/22/2013, indicated that suction toothbrushing was to be administered twice a day; however, there was no comment on how to help overcome the individual's known challenging behavior associated with oral health care. The most recent oral hygiene record indicated a rating of "good"; however, the individual was reported to have had bleeding of the gum tissue, light calculus buildup, and "moderate periodontal disease" at the time of the annual dental examination, indicating a need to enhance oral health care. The most recent annual dental examination, and the most current IRRF indicated that the Individual required oral sedation for all dental examinations and treatments; however, it was also noted that oral sedation was only moderately helpful, and there was no discussion about alternative forms of therapy, such as alternative oral sedation, or the possible need for i.v sedation. The annual dental examination indicated that there was no abnormal pathology, but reported moderate periodontal disease. The most recent annual dental summary did not document dental mobility issues, missing teeth, or bruxism, as reported in previous years. Individual #367 The annual IRRF, dated 1/4/2013, documented oral health and dental issues very well,	

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		and included strategies to better enable the Individual with oral hygiene compliance. Although it was documented that the Individual refused dental imaging studies, there was no strategy developed to help improve compliance with dental imaging studies. The PNMP did discuss adverse compliance issues, and strategies to help overcome poor oral hygiene compliance, and did not indicate the need for Chlorhexidine rinse. Also, the annual dental summary, dated 1/22/2013, indicated the need for verbal prompting to assist with brushing teeth, but this procedure was not delineated on the PMNP. The most recent annual dental summary did not comment on dental mobility, missing teeth, or bruxism, as reported in previous years. Individual #474 The annual dental examination, dated 3/13/2013, indicated "fair" oral hygiene, "moderate" periodontal disease, and did not document on dental mobility, missing teeth, or bruxism, as reported in previous years. The most recent IRRF, dated 3/13/2013, indicated that the individual had "slight" periodontal disease, and "good" oral hygiene, which contradicted the annual dental examination. The IRRF did document a comprehensive assessment of toothbrushing needs, and strategies to overcome related behavioral challenges. The IRRF documented the need for i.v sedation for dental exams, and treatments, but did not comment on associated risks with i.v sedation, and specific precautions and monitoring parameters for the use of i.v sedation. Three was no PNMP developed for oral health issues. Individual #163 The IRRF indicated that the Individual was to use "flavored" toothpaste, and a "spin" toothbrush; however, the PNMP did not indicate these preferences, or the need for a specialized toothbrush. The annual dental examination indicated that the individual had "moderate" periodontal disease, but this issue was not communicated in the IRRF. The most recent annual dental summary did not document dental mobility issues, missing teeth, or bruxism, as reported in previous years. Individual #580 The most recent IRRF provided an excellent review of oral health issues, and indicated strategies to overcome behavioral related challenges; however, the most recent PNMP did not reflect the specific oral health plan, as delineated on the IRRF.	

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		Individual #416 The most recent PNMP, dated 5/09/13, provided excellent insight into oral health care needs, and well documented specific oral health strategies; however, the most recent IRRF, dated 5/9/2013 did not document the same strategies as delineated on the PMNP. The most recent annual dental summary did not document dental mobility issues, missing teeth, or bruxism, as reported in previous years. Individual #335 The most recent IRRF indicated that the oral health was rated as "good"; however, it was noted on the annual dental examination, and the IRRF, the individual was noted to have moderate plaque and calculus; hence, the Monitoring Team is concerned that the oral health rating process may need to be reconsidered. The most recent IRRF commented on the need for an electric toothbrush, but the PMNP did not comment on the need for an electric toothbrush The most recent annual dental examination, dated 1/7/2013, did not indicate the level of periodontal disease. The most recent annual dental summary did not document dental mobility issues, missing teeth, or bruxism, as reported in previous years. Individual #581 The most recent PMNP, dated 6/6/2013, documented well the Individual's oral health care plan, by commenting on the type of toothbrush, and other necessary supports, as reflected in the IRRF. Given worsening of oral health care, from a periodontal rating from II to III, the Monitoring Team was concerned that the IRRF and PMNP did not reflect the need to re-evaluate the current oral health care plan. The IRRF provided an excellent overview for the use of oral sedation but did not document associated risks of oral sedation. The most recent annual dental summary did not document dental mobility issues, missing teeth, or bruxism, as reported in previous years. Individual #697 In this case, the most recent IRRF and ISP were provided. A description of dental issues and required supports was not addressed in either of the reports.	

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		The most recent IRRF, dated 5/3/2013, indicated that the Individual is provided i.v sedation for dental treatments, but there was no documentation of the risks associated with i.v sedation. The most recent annual dental summary did not document dental mobility issues, missing teeth, or bruxism, as reported in previous years. Individual #520 The most recent IRRF and PMNP did not indicate issues related to the individuals edentulous status. The Monitoring Team noted significant improvement with regard to documenting dental related issues within the context of the IRRF and PMNP; however, the Monitoring Team was concerned with the discrepancy between assessing the quality of oral hygiene, and the actual oral health assessments. Also of concern was the discrepancy among issues documented on the IRRF and the PMNP. The Monitoring Team was impressed by the Facility's exceptionally low number of delinquent annual dental assessments. While reviewing information for this report, the Monitoring Team experienced significant challenges with reviewing scheduling information, and noted that the dental office could not efficiently provide specific data elements, as requested. For example, the DSP conference calendar was used to provide the Monitoring Team with information regarding who was current, and not current, with their annual dental exam, and details about past and pending treatments. Fortunately, the Facility has functionalized the DADS dental database, which will enable efficient and effective tracking of dental services. Compliance will require: • Enhanced determination of quality of oral health care, when comparing findings to the actual dental and hygiene assessment of bleeding gums, periodontal disease, dental carries, and plaque. • Improved consistency of oral health care issues among the dental record, IRRF, and PNMP. • An efficient means of tracking dental database elements, with regards to treatments pending, treatments provided, tracking of dental imaging studies, need for pre-treatment sedation, i.v. and general anesthesia (intubation), restorative treatments, annual examinations, and dental hygiene. • Improved documentation of dental issues on the annual dental summary, such as missing teeth, dental mobility, dental carries, bruxism, and screening for oral cancer.	

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		Oral Hygiene at the Living Area To asses oral hygiene efforts at the living area, the Monitoring Team requested all associated policies and procedures; dental records, IRRFs, and PMNPs for Individuals #170, #367, #474, #163, #416, #580, #335, #581, #697, and #520; and associated quality assurance assessments, specific to monitoring the provision of oral hygiene at the living area. The Monitoring Team reviewed oral hygiene issues, as part of its review for Annual Dental Examinations, Dental Hygiene, and Schedule for Oral Health Care, which can be found above. Specific to the delivery of oral hygiene at the living area, the Monitoring Team noted significant improvement in documenting oral hygiene issues on the PNMP; however, in many cases, the specific plan, did not match what was outlined either on the related IRRF, or annual dental assessment (as delineated above). In addition, the dental director informed the Monitoring Team that at the time of this review, there was no formal mechanism in place to routinely assess the provision of oral hygiene at the living area. In addition to the noted improvements, compliance will require: • Improved consistency of oral health care issues among the dental record, IRRF, and PNMP. • Implementation of a process to routinely assess the provision of oral hygiene at the living area. Clinical Monitoring of Oral Sedation To assess the Facility's ability to monitor, from a list of all individuals who received oral sedation during the past six months the Monitoring Team requested the following information for the first ten individuals: all IPNs associated with the monitoring of sedation; associated dental record notes, copy of the ISP documenting the use of oral sedation; clinical data demonstrating the monitoring of sedation; and related dental record notes. In addition, the Monitoring Team requested an alpha list of all individuals who require pre-treatment oral sedation for dental services, and a copy of all data, data analysis, and related committee meeting minutes that were completed within the past 12 months, specific to the Facility's use of pre-treatment oral sedation for dental services. Also requested was a comparison list of individuals who were provided oral sedation in the past six months, and if they developed pneumonia during the past six months, the date of diagnosis. The Facility did not provide an alpha list of all individuals who require pre-treatment	

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		oral sedation for dental services. Only a list of individuals who received pre-treatment oral sedation for dental services during the past six months was provided. Review of comparison data for pneumonia and the administration of oral sedation that occurred during the past six months, indicated no correlation between the two elements; however, in two cases, the date that the individual was administered oral sedation was not provided for this review: • Individual #76, was reported to have developed pneumonia on 5/27/2013, and died on 6/29/2013, from complications of pneumonia. The administration date for oral sedation was not provided, and in place of the date, it was stated simply "deceased". For this reason the Monitoring Team could not determine if there was a possible correlation between being administered oral sedation, developing pneumonia, and subsequent death. • Individual #769 was diagnosed with pneumonia on 6/16/2013, and died on 7/19/2013. The administration date for oral sedation was not provided. The following is an overview of the ten cases selected for review: • In ten out of ten case (100%), there was a dental record entry that described the dental issue, treatment received, challenges, and follow-up plan. • In eight out of ten cases (80%) there was a specific IPN written by the dental office that delineated the dental issues, and specifics to the use of oral sedation. • In six out of ten cases (60%), there was a nurse's IPN addressing the clinical issues specific to the use or oral sedation. • In five out of ten cases (50%), a copy of the dental anesthesia record was provided for review, and documented monitoring parameters during the procedure. Anesthesia records were not provided for five out of ten cases (50%). • In nine out of ten cases (90%), the nurse documented a pre-sedation assessment of mental status and vital signs. • In seven out of ten cases (70%), the nurse documented post sedation monitoring on the procedure and recovery monitoring form, per protocol. Post sedation monitoring forms were not provided for two out of ten cases. • The medical restraint checklist was fully completed by the nurse in zero out of ten cases (0%). In only two cases, was DSP instruction documented, and in no cases was there post sedation monitoring information completed. • Specific information documenting the use of oral sedation for dental services was provided in zero out of ten cases (0%). • Per review of the provided IPNs, there was no evidence to support that nursing staff or DSPs monitored the individual through 24 hours following the procedure, although there were occasional nursing IPNs documenting such	

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		monitoring. The following are specific examples for four of the ten cases reviewed: Individual #352 • Pre-treatment monitoring was completed, per protocol, by nursing staff. • Oral Sedation monitoring was completed by nursing staff at the infirmary. • The post sedation monitoring form was not fully completed by nurses at the living area, although, there were some nursing IPNs documenting follow-up to post anesthesia in the clinical record. • The anesthesia record completed at the dental office appropriately documented clinical monitoring. • The procedure and recovery monitoring form indicated two assessments following a REACT score of 8 or more; however, there was no indication of who performed the monitoring, and documentation of the monitoring. • Per review of the provided IPNs, there was no evidence to support that nursing staff or DSPs monitored the individual through 24 hours following the procedure. • The nursing IPN did not document clinical issues specific for post sedation monitoring. • The dental progress note addressed the Individual's challenges, dental issues, and plan. • The dental IPN addressed the dental and behavioral issues, and follow-up plan. • There was no evidence to support that the use of oral sedation, which included rationale for use, and associated risks and benefits, was documented in the context of the ISP. Individual #415 • There was no dental IPN for dental treatment on 3/7/2013. • There was an excellent nursing note documenting post sedation clinical issues. • The medical restraint form was not fully completed, as it did not include the monitoring checklist, or post sedation monitoring. • The DSP instructions were not documented on the monitoring restraint form, and the restraint form was not reviewed by the unit director or designee. • The procedure and recovery monitoring form was completed, per protocol. • The anesthesia record was not provided for review. • There was no evidence to support that the use of oral sedation, which included rationale for use, and associated risks and benefits, was documented in the context of the ISP. • There was no evidence to support that nursing staff or DSPs monitored the	

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		individual through 24 hours following the procedure. Individual #334 • The dental IPN, for treated on 3/7/2013, was well documented, and included the dental issues, treatments provided, challenges experienced, and follow-up plan. • There was a nursing IPN for post sedation monitoring on 3/7/2013, at 2120, and on 3/8.2013, at 0100. The 3/7/2013 did not include vital signs, and the complete nursing note for 3/8/2013 was not provided, as the nursing note continued onto a second page, which was not provided for review. • The medical restraint form was not fully completed, as it did not include information on the section for post sedation monitoring, DSP instructions, and was not reviewed by the unit director. • The procedure and recovery monitoring form was completed, per protocol; however, there was no signature or initials indicating who performed the monitoring and documenting of the vitals. • The anesthesia record was fully completed. • There was no evidence to support that the use of oral sedation, which included rationale for use, and associated risks and benefits, was documented in the context of the ISP. • Per review of the provided IPNs, there was no evidence to support that nursing staff or DSPs monitored the individual through 24 hours following the procedure. The Monitoring Team compliments Facility for its overall enhancement of closely monitoring individuals who received oral sedation, while provided oral health treatment at the dental office and infirmary. Substantial compliance will require improvements in the following area: • Evidence to support that post sedation monitoring continues at the living area, by the nurse and DSP. • Accurate and full completion of all forms, such as the medical restraint form. • Ensure that DSPs are provided post sedation monitoring information, as documented on the restraint checklist. • The use of pre-treatment oral sedation is well documented within the context of an ISP. <u>CLDP and Post Move Monitoring Process</u> The Monitoring Team did not review specific CLDPs and post move monitoring assessments for Provision Q.1; however, the Monitoring Team did discuss the issue with the dental director, and reviewed findings noted in Provision T1e, of this report.	

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		At the time of this review the dental director was in the process of reviewing the CLDP and post move monitoring process, and was developing strategies to ensure meaningful participations in this process by the dental office. The Monitoring Team informed the dental director that such participation will be assessed during subsequent reviews. The reader is referred to Provisions T1e and T1a, for specific concerns related to the lack of clinically relevant participation in the IDT, ISP, CLDP, and post move monitoring process. Substantial compliance will require that the dental office develop and implement a process to ensure that a clinically relevant oral health treatment plan is incorporated into the CLDP, that a dentist at the new living site has reviewed the oral health needs and proposed treatment plan and accepted the individual as a client, and that supports needed by individuals are listed in the CLDP and monitored for the post move monitoring process.	
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.	To assess compliance issues for section Q.2, the Monitoring Team reviewed the Facility's processes related to dental QA, issues related to dental anesthesia, and dental scheduling. <u>Dental Quality Assurance (QA)</u> The Monitoring Team was informed by the dental director that the Facility had developed a robust dental quality assurance process, that included an external dentist to review the efficacy of dental treatments; however, there was no process to specifically address adverse outcomes from oral health services, such as injuries, behavioral exacerbation, and pneumonia, following the provision of oral health evaluations and treatment. Upon reviewing medical QA process for Provision L.3 of this report, the Monitoring Team noted that the Facility's QA department was tracking and analyzing data for outcome measures to assess the quality of dental treatments, and for aspiration pneumonia which occurred following dental sedation; however, monitoring for all types of pneumonia, all injuries, and all behavioral exacerbation following any type of dental evaluation or treatment, should be considered. Also, the dental QA process should be regularly utilized by the dental director, so that dental process improvements can be developed and implemented. The Monitoring Team compliments the Facility for its self-assessment of oral health treatment. Substantial compliance will require the Facility to develop a process to conduct a systems review of dental outcome data, that includes a review of potential adverse outcome, including the development of pneumonia (all types), injuries, and behavior exacerbation. In addition, the dental director should utilize the outcome data to develop and implement process improvements to enhance clinical outcomes.	Noncompliance

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		Dental Schedule The Monitoring Team assessed issues related to dental scheduling as a component of Provision Q.1, and the reader is referred to that section for further details. It was noted that the Facility had developed a mechanism to better track missed appointments, and there had been a significant improvement with missed dental appointments, compared to previous reviews. Also, the dental office had functionalized the dental database, which will enable better tracking of the dental schedule and dental treatments. The Monitoring Team is complimentary for both actions. Programs to Help Minimize Restraint To assess the Facility's ability to better enable least restrictive oral health care treatment, the Monitoring Team requested the Facility's most recent policies, specific to minimizing restraint use; an alpha list of all individuals who were provided specific programs to help mitigate the use of dental sedation; an alpha list of all individuals who were unable to complete their dental visits because of challenging behaviors, and not currently participating in a program to help minimize the use of sedation; and for the first ten individuals on the list of individuals whom were provided a program to help mitigate dental sedation: copy of their program, associated data, and copy of the current ISP or addendum to ISP that documents the use of the program, and expected outcome. The Monitoring Team reviewed the Denton State Supported Living Center Procedure: Strategies to Reduce Medical/Dental Restraint, dated 04/19/2013. The procedure was comprehensive and clearly delineated roles and responsibilities of relevant staff and departments; however, the Monitoring Team noted that the procedure did not include discussion about how often dental desensitization would occur, at the level of the Individual. The Monitoring Team compliments the Facility for including a comment that "Dentist will use clinical judgment to determine if sedation or physical or medical restraint should be used without an attempt being made". The Facility provided a document listing "individuals not currently participating in a process to help minimize the use of sedation." Comparing this list to a list of all individuals who required "Dental Sedation/TIVA" and had not been referred to the Behavioral Services department for program development, the Monitoring Team noted significant discrepancy. For example, the following individuals were identified as requiring dental sedation, and were not on the list of individuals who were "not currently participating in a process to help minimize the use of sedation": Individuals #288, #194, #186, #763, #760, #512, and #753, among many others. The Monitoring Team has concern that this discrepancy indicates that the Facility has yet to develop a meaningful process to identify and track individuals who require dental sedation.	

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		The Monitoring Team reviewed the ten active programs provided for review, and determined that the programs were implemented at frequencies that would not benefit the individual, as most individual were provide program training, two or less occasions per month. For example: • Individual # 534's program was implemented on 5/8/2013; the individual received training on a total of four occasions, and no behavioral improvements were reported. • Individual #169's program was implemented on 9/19/2012; in the past six months, the individual was provided a total of nine training opportunities, and no behavioral improvements were reported. • Individual #189's program was implemented on 9/19/12; the individual was provided ten training opportunities in the past six months, and no behavioral improvements were reported. • Individual #376's program was implemented on 9/19/2012; the Individual was provided ten training opportunities in the past six months, and no behavioral improvements were reported. • Individual #669's program was implemented on 5/8/2013; the individual was provided two training opportunities in the past two months, and no behavioral improvements were reported. • Individual #204's program was implemented on 8/1/2011; the individual was provided 13 training opportunities in the past six months, and no behavioral improvements were reported. The Monitoring Team compliments the Facility for ensuring that for each of the ten samples reviewed, there was an associated ISP that delineated the program to help minimize the use of restraint. Compliance will require additional improvements in the following areas: • There must be an accurate accounting of database elements, specific for programs to help minimize the use of sedation. For example, the Facility must effectively track all individuals who have been assessed for a program, have not been assessed, as well as outcome data that will help establish efficacy of the program. • Ensure that all individuals have been assessed for a program to help minimize the use of sedation. • Ensure that training opportunities occur at a frequency that benefits the individuals. <u>Total Intravenous Anesthesia (TIVA)</u>	

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		To determine the Facility's availability of providing adequate quantity of TIVA services for dental procedures, and to assess the Facility's process for ensuring safe administration of TIVA, the Monitoring Team request a list of all individuals who required TIVA for their oral healthcare needs, a list of all individuals who received TIVA during the most recent six months, and for the last five individuals on the list: copy of TIVA records, and nursing notes associated with post anesthesia monitoring. For a five month period, beginning February 1, 2013, a total of 106 individuals were assessed, and, or treated under i.v sedations, for oral healthcare issues, which is an average of 21 individuals per month: February: 29 March: 31 April: 16 May: 14 June: 16 Total: 106 The Facility reported that a total of 104 individuals require TIVA for oral health care. Based on current contract with the anesthesiologist, the dental director reported that the Facility could expand TIVA resources to meet increased demand. Based on the number of individuals reported to need routine TIVA services for oral healthcare issues (104), and by extrapolating the number of individuals provided TIVA, during a five month period (106), for a period of 12 months, the Monitoring Team determined that the Facility has the capacity to provide at least 300 opportunities for TIVA, during a one year period, and therefore provides adequate TIVA resources for individuals who require TIVA for their oral healthcare needs. The following is a summary of findings from the review of sample cases provided (Individuals #204, #699, #391, #661, and #472) • In five out of five cases (100%), anesthesiology records were complete, and documented all necessary monitoring parameters. • In five out of five cases (100%), there was documentation of necessary monitoring parameters by the infirmary nurse, until the individual reached a REACT score of greater then or equal to eight, on two consecutive occasions. • In five out of five cases (100%), the dental office ensured that serious side effects of the anesthesia provided were communicated to the living area. • In five out of five cases (100%), the nurse performed, and documented pre-sedation assessment. • In five out of five cases (100%), the dental office informed the living area, including the unit supervisor, responsible nurse, of the procedure, and potential	

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		issues related to TIVA. • In five out of five cases (100%), the dental office provided post-sedation orders, including monitoring parameters, to be completed at the living area. The Monitoring Team did not request documentation to assess post sedation follow-up at the living area by the nurse and DSP, but will do so at the time of future reviews. The Monitoring Team was impressed by the Facility's TIVA program, and compliments the Facility on providing ample TIVA services, and for ensuring exceptional post anesthesia monitoring during the procedure and follow-up at the infirmary. <u>Oral Sedation</u> Oral sedation for dental services is assessed as a component of Section J, and the reader is referred to Provision J13 for specific details and the Monitoring Team's findings. The reader is also referred to information on a sample of individuals reported in Provision Q1 for additional information. <u>General Anesthesia (intubation)</u> The dental director reported that the Facility has not identified anyone who required general anesthesia through intubation; however, if needed, they would refer the individual to the local hospital for such service. The Monitoring Team compliments the Facility for having a process to provide general anesthesia (intubation), for individuals who may require such resource in the future. The Monitoring Team is extremely impressed with the Facility's improvements in the areas of reducing missed dental appointments, and monitoring close monitoring of individuals who received dental services under anesthesia, and oral sedation. There has been noted improvements in further enhancing programs to minimize sedations. However, because the Facility's lack of a specific dental quality assurance program, inadequate programs to help minimize the need for sedation, need to improve on assessing the needs of individuals for programs to help minimize the use of sedation, and need to enhance documentation of post sedation monitoring, on the Facility's specific forms, the Monitoring Team determined that the Facility is non-compliant with section Q.2, of the Settlement Agreement.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self Assessment 7/8/13 2. DSSLC Action Plan 6/21/13 1. Facility Section R Presentation Book 2. DSSLC Communication Services Policy CMGMT-23, rev 11/1/09 3. Record Reviews of Individuals: • Sample R.1: Individuals #32, #111, #186, #282, #382, #383, #391, #467, #684, and #760 • Sample R.2: Individuals #165, #172, #248, #276, and #781 • Sample R.3: Individuals #125, #153, #334, #449, #472, #689, #731, and #766 • Sample R.4: Individuals #32, #111, #382, #467, and #760 • Sample R.5: Individuals #32, #282, #383, #391, 467, and #684 4. Communication Master Plan 5. List of current SLPs, caseloads and ratios 6. Copies of each SLP's current license and ASHA certification 7. Continuing education and training completed by the SLPs in the past 12 months 8. Facility list of new admissions since the last review 9. Tracking log of SLP assessments completed since the last review 10. Facility list of individuals with severe language deficits 11. Facility list of individuals with PBSPs and replacement behaviors related to communication 12. PBSP minutes and attendance rosters for the past six months 13. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 14. Facility AAC screening forms 15. Facility AAC-related database reports/spreadsheets 16. Facility list of general common area AAC devices 17. Facility list of individuals receiving direct communication-related intervention plans **People Interviewed:** 1. Becky Nurre CCC-SLP Director of Speech Therapy 2. Donna Groves OTR Director of Habilitation Services 3. Seven DCPs (Garden Ridge, Cedar Falls, Timberhill, and Eastfield) **Meeting Attended/Observations:** 1. Mealtimes and Transitions- Garden Ridge, Cedar Falls, Eastfield, and Timberhill
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 7/8/13 and Action Plan dated 6/21/13. 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. 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.1 through R.4. This was consistent with the

	Monitoring Team's findings of noncompliance with all the Provisions. For Section R in conducting its self-assessment: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section R. o This monitoring/audit tool did not include adequate indicators 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, Provision R.1 in the Self-Assessment did not address if the current number of SLPs were sufficient in meeting the needs of the individual and to carry out all components of the Communication Policies. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. o The Self-Assessment did identify the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools (i.e., OTs, PTs, and SLPs); therefore, there was no evidence that staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. ▪ The Facility did consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did measure the quality as well as presence of items. o Did distinguish data collected by the QA Department versus the program/discipline. Overall, the Self-Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report.
	Summary of Monitor's Assessment: Overall, Speech Assessments continued to improve but lacked information regarding comparative analysis. While the assessments were rolling in nature, the comparative analysis was vague at times and did not fully provide status comparison. Implementation of communication programs remained low and staff knowledge of how to form effective communication with the individuals was not evident at the home level. That being said, implementation at Cedar Falls had shown improvement; therefore, it would benefit DSSLC to use that home as a model for implementation at other homes. **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. Additionally, facility policy lacked the guidelines needed to ensure consistency in implementation. **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 when opportunities for increased communication were presented. **Provision R.3:** This provision was determined to be not in compliance. The ISP did not have communication interventions consistently integrated into the individual's daily routine, and general area AAC was either not utilized and/or was nonfunctional. **Provision R.4:** This provision was determined to be not in compliance. DSSLC did not have a comprehensive monitoring system with corresponding guidelines that covered the presence and condition of the device, implementation of the device, as well as SLP participation in care. Additionally, the monitoring recommendations should be included as part of the assessment process and contained within the assessment.

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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.	Samples for this section are as follows: Sample R.1: Consisted of 10 Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Consisted of five Individuals receiving direct speech services. Sample R.3: Consisted of eight Individuals with a PBSP and communication deficits. Sample R.4: Consisted of five Individuals from R.1 above with AAC systems Sample R.5: Consisted of six individuals from R.1 who received indirect Speech Services/Supports. **Staffing** The Facility did not provide an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. As of this review, DSSLC was fully staffed with six SLPs and had recently opened a newly added position for a Speech Pathology Assistant (SPA). The SPA would help provide modeling as well as assist in the development of plans and programs as well as assist	Noncompliance

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		with the monitoring process. The current staffing allowed for a caseload as listed below: • Sandra Leung: 88 Individuals • Sherri Tuggle: 75 Individuals • Benette Gaskill: 81 Individuals • Linsay Lilly: 85 Individuals • Elizabeth Evans: 83 Individuals • Mimi Zatout: 99 Individuals Per interview with the Director of Speech, it was stated that a more reasonable caseload would average a caseload of 65 Individuals and would allow for the increased presence of Speech staff on the units outside of only providing assessments. The Monitoring Team was in agreement as an acceptable caseload for individuals with complex needs is generally in that ratio. Having a more manageable caseload allows the clinician to more actively be part of the team and provide increased modeling on the homes and thus assist the staff in learning to how better be able to utilize devices in their natural environments. **Qualifications:** Four of four positions for SLPs (100%) for which documents were provided to the Monitoring Team were filled by licensed SLPs • Four of four SLPs (100%) were licensed to practice in the state of Texas. • Four of four SLPs (100%) had evidence of ASHA certification. Two more SLPs were hired in June 2013 but the Monitoring Team was unable to review their qualifications as the information was not provided with the document request. **Continuing Education:** Based on a review of continuing education completed in the last 12 months, four of four SLP staff (100%) had completed continuing education related to communication in an area that was relevant to the population served. Education included but was not limited to: • AAC and Autism • The Tablet Revolution and AAC **Facility Policy** A local policy/process did not exist that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services. DSSLC had a localized Communication Services Policy (CMGMT-23, rev 11/1/09). The policy contained the following components:	

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		• Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Timelines for completion of new admission assessments • Criteria for providing an update • Outlines assessment schedule. • Frequency of assessments/updates. Missing from the policy was: • Addressing a process for effectiveness monitoring by the SLP. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication • Methods of tracking progress and documentation standards related to intervention plans. While the areas above were included as part of a draft policy, the policy had not yet been formalized and the procedures/guidelines defining the specifics of how the missing components would be implemented was still a work in process and per the Director of Speech were not ready for formal review by the Monitoring Team.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Assessment Plan:** The Facility had a reasonable plan to screen/assess all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. DSSLC provides assessments for all new admissions in lieu of providing screenings. Individuals at a minimum are provided with a Communication Assessment annually if they receive direct or indirect communication supports and all others will be provided with assessments if there was a change in status, IDT request or at a minimum will be provided with a screening every 5 years. At the time of this review, this schedule of assessments or the type of screening or format of subsequent assessments has not been developed and/or finalized and will need to be reviewed at the next compliance visit. The Facility did define the timeframe for the completion of communication assessments for individuals within their defined priority levels. Per review of DSSLC's Master Communication Plan, a definition of each priority level for individuals with communication needs who would benefit from the use of alternative or augmentative communication systems (AAC) was provided. Communication screenings and assessments for individuals within these priority levels had been completed within the	Noncompliance

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		timeframe established by the Facility and in many cases were ahead of schedule. Per the DSSLC guidelines, all individuals will have received a comprehensive assessment by December 2015 but per interview, it was expected that this goal might be reached sooner than the 2015 deadline. As of this review: • 102 of 103 (99%) priority 1 individuals had been provided with a comprehensive assessment • 134 of 137 (97%) priority 2 individuals had been provided with a comprehensive assessment • 26 of 81 (32%) priority 3 individuals had been provided with a comprehensive assessment • 18 of 102 (17%) priority 4 individuals had been provided with a comprehensive assessment • 16 of 89 (17%) priority 5 individuals had been provided with a comprehensive assessment **Assessments Provided** Ten of 10 individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. All individuals in Sample R.1 received assessments annually if the individual was provided with direct or indirect services. Sixteen of 16 individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission. For nine of 10 individuals in Sample R.1 (90%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Fifteen of 15 individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. **Communication Assessment:** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Zero of 15 individuals' Communication assessments (0%) were signed and dated by the clinician upon completion of the written report; • Thirteen of 15 individuals' Communication assessments (86%) were dated as completed at least 10 working days prior to the annual ISP; • Fifteen of 15 individuals' Communication assessments (100%) included diagnoses and relevance of impact on communication; • Fifteen of 15 individuals' Communication assessments (100%) included	

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		individual preferences, strengths, and needs • Fifteen of 15 individuals' Communication assessments (100%) included medical history and relevance to communication • Zero of 15 individuals' Communication assessments (0%) listed medications and discussed side effects relevant to communication; • Thirteen of 15 individuals' Communication assessments (86%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Fifteen of 15 individuals' Communication assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Fifteen of 15 individuals' Communication assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Fifteen of 15 individuals' Communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; • Fifteen of 15 individuals' Communication assessments (100%) included discussion of the expansion of the individuals' current abilities. • Fifteen of 15 individuals' Communication assessments (100%) provided a discussion of the individuals' potential to develop new communication skills; • Fifteen of 15 individuals' Communication assessments (100%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification; and rationale as to whether or not the individual would benefit from AAC or EC. • Zero of 15 individuals' Communication assessments (0%) offered a comparative analysis of health and functional status from the previous year • Eight of 15 individuals' Communication assessments (53%) gave a comparative analysis of current communication function with previous assessments. While the assessment compared status to previous assessments, the information contained within the analysis was less than comprehensive and therefore difficult to fully determine if any progress was made in that specific area. For example: Individual #467's previous assessment stated that emerging object permanence was present but provided no further information. • Fifteen of 15 individuals' Communication assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • Fifteen of 15 individuals' Communication assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation	

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		among various staff; • Fifteen of 15 individuals' Communication assessments (100%) had a reassessment schedule; • Zero of the 25 individuals' Communication assessments (0%) supplied a monitoring schedule. The SLP assessment did not discuss monitoring results from the previous year and did not recommend the implementation of a monitoring schedule for the upcoming year. • Fifteen of 15 individuals' Communication assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. • Fifteen of 15 individuals' Communication assessments (100%) made a recommendation about the appropriateness for community transition. • Fifteen of 15 individuals' Communication assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. **SLP and Psychology Collaboration:** Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs), the following was noted: • Eight of eight communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. • For four of eight individuals (50%) communication strategies identified in the assessment were included in the PBSP. • For eight of eight individuals (100%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets for the eight individuals in sample R.3, participation by a SLP was noted in eight of eight (100%) meetings. The SLPs and psychologists continue to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. SAPs developed by Speech were reviewed and found to be much improved in their consistency with the PBSP as well as the level of detail provided to staff regarding implementation.	
R3	Commencing within six months of	**Integration of Communication in the ISP**	Noncompliance

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	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.	Based on review of the ISPs for individuals in Sample R.1 and R.2 the following was noted: • In 14 of 15 ISPs reviewed (93%) for individuals with communication needs (programs and goals, Priority 1-3 in Master Plan and/or lists identifying those with communication deficits) an SLP attended the annual ISP planning meeting, or the team provided adequate justification. • Fourteen of fifteen ISPs reviewed (93%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. • Communication Dictionaries for 15 of 15 individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Ten of 15 ISPs reviewed (66%) included how communication interventions were to be integrated into the individual's daily routine. • Fourteen of 15 ISPs reviewed (93%) contained skill acquisition programs to promote functional communication. • Ten of 15 ISPs reviewed (66%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** For seven of seven individuals in Sample R.1 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days. Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following: • Three of five observations (60%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for one of six individuals (16%) were noted to be in use in each observed setting. • AAC systems for five of five individuals (100%) were portable. • AAC systems for five of five individuals (100%) were functional. • For two of five individuals (40%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices:** Observations were completed in six homes and to determine the presence and use of general AAC devices. Findings included the following: • Four of the six homes (67%) had general use AAC devices present in the	

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		common areas. General area devices were not noted in 508a. • In four of six homes and other environments (66%), general use AAC devices were operational. • Zero of the six general use AAC devices (0%) noted contained clear directives on how staff should use these devices. • Four of four general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of four general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been appropriate (for example: mealtimes, washing hands, music) but were not prompted by staff or utilized by the individuals. Overall, General area devices were not well marked with directions and had no evidence of being utilized outside of Cedar Falls, which contained more service objectives aimed at individuals. Devices were either broken or not used by individuals or encouraged to be used by staff. Examples was on 508C where a dresser and box fan were placed in front of the communication device and on 523A where an environmental control device was hooked to a radio but the instructions were for requesting a hairbrush. Another example was on 523b where the majority of wall devices were missing the needed photos and did not have directions for use. In order to move towards substantial compliance, DSSLC must develop a consistent monitoring process that will ensure all devices are working properly and staff are provided consistent modeling on how to use the devices. **<u>Direct Communication Interventions</u>** Review of the individuals' records from Sample R.2 showed the following: • Five of five individual's direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For zero of five individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For five of five individuals (100%), information was present regarding whether the individual showed progress with the stated goal. • For zero of five individuals (0%), a description was found of the benefit of the device and/or goal to the individual. There was no evidence that the therapist reported on a monthly basis how the goal would support communication for the	

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		individual in their daily activities. • For five of five individuals (100%), a report was found regarding the consistency of implementation. • For five of five individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • For one of the one individual reviewed for whom intervention was terminated (100%), termination of the intervention was well justified and clearly documented in a timely manner. • For five of five individuals (100%) progress notes contained the consistency of implementation. • For five of five individuals (100%) progress notes occurred at a minimum monthly. **Indirect Communication Supports:** Programs for individuals in Sample R.5 who received indirect communication supports were reviewed and found: • Six of six individuals' indirect plans (100%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For six of six individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For five out of five individuals in Sample R.4 (100%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. Zero of six individuals (0%) receiving indirect Speech Services (Sample R.5) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for zero of 20 individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. Review consisted of only stating that the service was provided and offered minimal information regarding effectiveness of supports in meeting desired outcomes. • Quarterly documentation for zero of six individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of six individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of six individuals (0%) identified recommendations/revisions to the program as indicated and related to the	

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		individual's progress or lack of progress. **Staff Interviews** Three of seven staff interviewed (42%) were knowledgeable of the individual and their communication related programs; direct support professionals had difficulty with the following questions • Stating whether the individual had an AAC system. • Whether there was a communication program. • Describing the communication program goal. • Described the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. **Competency-Based Training and Performance Check-offs:** Based on review of the NEO training curriculum, and individualized training, DSSLC did develop comprehensive competency based training regarding communication services. • The training materials reviewed did address all the appropriate content areas listed below: o Methods to enhance communication o Implementation of programs o Benefits and use of AAC o Identification of non-verbal means of communication. 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. Per the Director of Speech, this was an area that would improve if there was increased staffing but as of this review, time was not available to conduct this task at the level needed. One hundred fifty six of 158 new employees between November 1, 2012 and March 31, 2013 (98%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. **Individual-Specific Competency-Based Training** To determine whether the Facility had a process to determine whether staff had been trained on their communication devices, the Monitoring Team requested evidence that all assigned staff for the five individuals in Sample R.4 had received training related to Communication SAPs and programs.	

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		Five of 5 (100%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs. Staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' plans prior to training others. There was no evidence that Staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' communication prior to training other staff on the AAC devices. While the name of the staff providing training was included on the form to as the trainer, there was no evidence that staff had been trained by the clinician who recommended the strategies and/or revisions.	
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.	**Policy and Procedure** A Facility policy and/or procedures did not exist that describes the monitoring system for communication provision of the ISP for individuals who would benefit from AAC. The Facility policy and/or procedures did not include the essential components related to monitoring. Missing from the process/policy was clear guidelines regarding the frequency in which the presence, working condition was to be monitored by the PNMPCs. Per the Director of Speech, the PNMPCs provided monitoring of object symbol cards at a more frequent basis initially (once weekly) and then decreased the level of monitoring to quarterly if no issues were noted. The concern was that there was no formal process in place and no definition of what constituted a concern or what measurable threshold would be utilized to decrease monitoring. Another process was in place that monitored if AAC devices were working and readily available but again there was no formal schedule or guidelines that directed the monitoring process. In addition to the working condition and presence monitoring that was to be conducted by non-clinicians, there was also effectiveness monitoring that would be provided by the Speech Pathologists at a frequency of once per quarter for all individuals who had a communication SAP or who received direct SLP treatment; like the other types of monitoring, there were no formal guidelines or schedule to ensure completion. **Monitoring of Implementation of Communication Supports** Compliance Monitoring forms for implementation of communication supports the last six months for three individuals from Sample R.5 were reviewed and the following was	Noncompliance

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		found: • For zero of five individuals (0%), monitoring of communication supports was outlined in the assessment. • For one of five individuals (20%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. There was not a formalized guideline that identified the frequency of monitoring. AAC monitoring was conducted that focused on presence and working condition, but this monitoring lacked a formalized process. Effectiveness monitoring of AAC was to occur quarterly but there was limited evidence that this consistently occurred. Two of 10 individuals from Sample R.1 (20%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. While the QDDP reviewed the supports, the information contained within the review was lacking detail regarding if the individual achieved progress and if the supports remained appropriate For example: Individual #684's reviews by the QDDP only stated that the individual was given opportunities to activate the device.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/2013 2. DSSLC Action Plan 6/21/2013 3. DSSLC Presentation Book for Section S 4. Documents that were reviewed included -- where available -- the annual ISP, ISP updates, Skill Acquisition Programs (SAPs), Positive Behavior Support Plans (PBSPs), Psychology/Functional Assessment (PAFA), 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. 5. Sample provided prior to site visit: Individuals #119, #276, #772, and #778 6. SAPs reviewed by BCBA: Individuals #13, #42, #411, #412,#673, #726, #742, #752, #766, and #783 **People Interviewed:** 1. Linda Ford – Director of Active Treatment 2. Trent Lewis – Vocational Services Director 3. Pung Nelson – Director of Life Skills Program 4. Randy Spence, MS – Director of Behavior Services 5. Laura Dittlinger-Harper, BCBA - Consultant 6. Approximately 20 direct care staff in the following residences and day treatment areas: Residence 508A, 508C, 523A, 523D, 525A, 527A, 527C, 528B, and 528D, as well as vocational settings ICD120, ICD121, ICD124, and ICD128 **Meeting Attended/Observations:** 1. Positive Behavior Support Committee 2. The following residences and day treatment areas: Residence 508A, 508C, 523A, 523D, 525A, 527A, 527C, 528B, and 528D, as well as vocational settings ICD120, ICD121, ICD124, and ICD128.
	Facility Self-Assessment: 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. At the time of the site visit, DSSLC reported in the Self-Assessment that Provision S.3.b was in substantial compliance with the Settlement Agreement. The Monitoring Team reviewed an abundance of information reflecting activities in the community. Due to weaknesses identified in the assessment for and development of SAPs, the Monitoring Team did not agree with the self-rating reported by the Facility in the Self-Assessment. For Section S, in conducting its self-assessment, the Facility:

	▪ Did use monitoring/auditing tools to assess the content of SAPs. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The SAP External Review Monitoring Tool • This monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools included adequate methodologies, such as such as record reviews and interviews with SAP authors. • The Self-Assessment identified the sample sizes, and included the number of individuals/records reviewed. No data were offered to reflect the relationship between the sample size and total number of SAPs. The sample size was adequate to consider it a representative samples. • The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. • The following staff/positions were responsible for completing the audit tools: Laura Dittlinger-Harper, BCBA • The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically competent in the relevant areas. • Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Although the Facility indicated that additional reviews were conducted of assessments and assessment reports, the tools used for the review were not described in the Self-Assessment. ▪ Used other relevant data sources, such as staff written reports, data for timely submission of evaluation reports, and observations. Although these data sources did result in hundreds of pages of information, it was not evident that a coherent process or mechanism existed for easily compiling and summarizing the information. ▪ The Facility consistently did not present data in a meaningful or useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Consistently did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program or discipline. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as In Process ▪ The Facility data did not identify areas of need/improvement. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. In the majority of Action Plan steps, the Facility presented a process or forms that were under development. This information did not address how the process or form could affect the

	quality of services or lead to substantial compliance.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at DSSLC from 7/22/2013 through 7/26/2013. 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. Even though the Facility had not achieved substantial compliance, the Facility had demonstrated greater progress over all than had been noted during previous visits. It was noted that dividing responsibilities for Section S across multiple staff appeared to have facilitated some of this improvement. In addition, the recruitment of external consultation also served to refocus efforts toward the core elements of skill acquisition training. This refocusing was important as in the past the Facility had attempted to achieve great progress with limited organization and goals that were too broad. A continuation of efforts to enhance organization and focus, with attention to efficiency as well would likely prove beneficial to further efforts toward substantial compliance. Based upon the information reviewed, it was evident that the Facility had achieved some progress in certain areas. • The Facility had implemented the services of a BCBA in training staff in relation to skill acquisition and the review of skill acquisition programs. • Since the beginning of 2013, 232 individuals had been provided assessment of adaptive skills. These assessments had been completed using standardized instruments. • The majority of elements of SAPs targeted for review reflected progress in comparison with previous site visits. • The Facility reported that substantially greater skill acquisition training was occurring in the community. Despite these areas of improvement, the Facility continued to experience areas of considerable weakness. • Although the use of standardized assessments of adaptive skills and intelligence had increased, there was little indication that the findings of these assessments were used in the development of skill acquisition programs. Information provided by the Facility did not reflect that the majority of skill acquisition programs were based upon adequate assessments or targeted needs specific to the individual. • The Facility had not demonstrated an effort toward ensuring that standardized assessments of adaptive skills were current or provided for all individuals newly admitted to the Facility. • Levels of functional engagement had not appreciably increased over levels observed two years previously. Furthermore, there continued to be residences at the Facility where functional engagement fell far below accepted levels, potentially placing individuals at risk. • Numerous data sheets for skill acquisition programs were not current or did not include data collected according to instructions in the program. • Several disciplines did not consistently provide assessment reports for ISP meetings within the required time parameters.

	Based upon record reviews, observations, and interviews with staff, although some progress had been achieved, there were no indications that the Facility had met requirements for substantial compliance in Section S of the Settlement Agreement.

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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.	<u>Use of Assessment Information in Planning Skill Acquisition</u> Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training. <u>Historical Perspective</u> During the initial March 2010 baseline site visit, it was noted that none of the 10 individuals included in the skill acquisition training sample had been provided with all of the necessary assessments. Several individuals had received medical or psychological assessments, but lacked assessments targeting mental illness, communication or adaptive behavior. During the 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. During the October 2012 site visit, the Facility did not provide the materials necessary to conduct the review. <u>Current Site Visit</u> <u>Use of Assessment Information in Planning Skill Acquisition</u> As part of the document request, the Facility was to submit for seven individuals the current ISP, SAPs, assessments, tracking data, and other supporting materials. For this sample of seven individuals, the Facility was to select what they considered examples of their best work. In addition, all samples were to reflect work completed since the last site visit. Of the records of the seven individuals included in the sample, only four included an ISP and SAPs completed since the previous site visit in October 2012. Due to the issues with the submitted documents, the sample for this portion of the review included only the four individuals whose records met the requirements of the document request. This limitation substantially curtailed the ability to develop conclusions regarding the ability of the Facility to utilize assessments in the ISP process and the formulation of	Noncompliance

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skill acquisition teaching strategies.

	03/2010	4/2012	7/2013
Skill acquisition plans are implemented to address needs identified in:			
ISP	0%	0%	25%
Adaptive skill or habilitative assessment	0%	0%	25%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	0%	0%
Skill acquisition plans are related to the individual's preferences.	0%	8%	0%

Based upon the limited sample available, it was suggested that DSSLC had not fully developed and implemented a process for providing comprehensive assessment or using assessment findings. Some of the weaknesses in the assessment process included the following.

- The submitted materials included only the FSA, Vocational Assessment, Psychology Psychological/Functional Assessment (PAFA), and psychiatric assessments. Although these are vital areas and should be included in ISP process, assessments from the other IDT disciplines should be integrated into the ISP and SAP development process.
- The tool most often cited as the basis for SAPs was the FSA. The development of SAPs requires a comprehensive and precise understanding of numerous facets of an individual's abilities and limitations. The FSA alone lacks the ability to provide such assessment and understanding. The FSA, however, could serve as the initial component to a more comprehensive assessment, helping to focus attention upon general skill areas in which the individual experienced limitations. It would then be necessary to supplement the FSA with assessments specific to the areas where skill deficits were suggested. This approach could lead to a more comprehensive understanding of the individual and lead to specific and individualized training. In addition, by providing assessment that is more precise, the potential is increased for identifying weaknesses that limit transition to more integrated environments and providing training that successfully addresses those weaknesses. There was no indication in the records reviewed that such supplemental assessments were used in developing skill acquisitions programs at DSSLC.
- An assessment of adaptive skills utilizing the Vineland Adaptive Behavior Scales – 2nd Edition (VABS2) – a standardized test of adaptive behaviors – was completed for each of the four individuals and reported in the Psychology PAFA. There was no indication in the ISP for any individual that the results of the VABS2 were

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		considered in the development of skill acquisition programs. In addition to the limitations noted in the assessment and SAP development process, there were also examples where limitations in the assessment and ISP processes adversely affected specific SAPs. • For Individual #119, a money management SAP was implemented to teach skills relating to making a purchase. The ISP stated that this SAP was based upon needs identified in the FSA. The FSA, however, indicated that the Individual was independent in all areas of money management except for balancing his checkbook and managing his own accounts. Other than one incident of refusal, the individual demonstrated independence in the skills being taught for over four months immediately following the implementation of the SAP. • A SAP was developed for Individual #778 to teach laundry skills. The only assessment referenced for this SAP was the FSA. The FSA, however, indicated only that the individual refused to engage in the task, not that the individual lacked the skills to perform the task. There was no indication that additional assessments were completed to determine if the individual should be taught the laundry skills or if an intervention to address motivational issues was necessary. Insufficient information was available to support comprehensive conclusions regarding the use of assessments in the development of skill acquisition programs. As the Facility was asked to include samples of "best work" in the submitted documents, it would appear fair to accept that the submitted documents reflected at least common practices at the Facility. Based upon the information obtained from the available, albeit small, sample, it was suggested SAPs were not being effectively developed and implemented at DSSLC. <u>Teaching New Skills</u> Teaching new skills requires the use of the same learning principles involved in changing undesired behavior. Therefore, effective skill acquisition programs require many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised. The sample for reviewing the components of SAPs included the four SAPs presented previously for this Provision. In addition, it was possible to add 10 SAPs to the sample. These SAPs were obtained in material submitted by Laura Dittlinger-Harper, the BCBA responsible for reviewing the content of SAPs and training staff on SAP development. These 10 SAPs reflected one program for each of 10 individuals, including Individuals #13, #42,	

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		#411, #412, #673, #726, #742, #752, #766, and #783. Skills and behaviors targeted by these SAPs included crossing the street, throwing a ball, writing name, identifying name and academic skills, It was not possible to include these 10 SAPs in the review of assessment and ISP practices, as these SAPs were not submitted with assessments of ISPs. Based upon the SAPs reviewed during the current site visit it was suggested that, despite the limitations in assessments, the components of the SAPs had improved since the April 2012 site visit. Only one element satisfied requirements in more than 90% of the reviewed SAPs (Opportunity for target behaviors to occur) and one element reflect a loss (Specific instructions). Overall, however, the data from the current site review reflected the first substantial increase in SAP quality at DSSLC since the initiation of the Settlement Agreement.	

	03/2010	4/2012	7/2013
Plan reflects development based upon a task analysis	0%	0%	21%
Behavioral objective(s)	0%	8%	36%
Operational definitions of target behavior	0%	8%	36%
Description of teaching conditions	0%	0%	21%
Schedule of implementation plans for sufficient trials for learning to occur	0%	23%	7%
Relevant discriminative stimuli	0%	23%	79%
Specific instructions	0%	0%	21%
Opportunity for the target behavior to occur	0%	69%	93%
Specific consequences for correct response	100%	0%	29%
Specific consequences for incorrect response	0%	0%	64%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	43%
Documentation methodology	0%	0%	29%

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

Task analysis

Conducting a meaningful task analysis is essential to the development of many, but not all, skill acquisition programs. For many individuals with intellectual and developmental disabilities, tasks and behaviors must be broken down into small, discrete steps that can be more easily learned. Task analysis is the process of breaking complex tasks or skills down into smaller steps in a way most beneficial to the individual who will be provided training.

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		Three of the 14 SAPs reviewed (21%) reflected development based upon an individualized task analysis. Examples of where SAPs did not reflect adequate task analyses included the following. • For Individual #673, the SAP included specific steps for learning to cross the street, suggesting that some form of task analysis was completed. In the narrative of the SAP, however, comments reflect a variety of factors that interfere with the individual's ability to cross the street safely, such as preoccupation with upcoming activities and racing thoughts. The steps included in the SAP did not address these issues, suggesting that whatever task analysis might have been completed did not address the unique needs of the individual. • The SAP for Individual #752 was described as a forward-chaining program, which would require a task analysis. The steps included in the SAP lacked precise descriptions of the behavior the individual was to perform and at times focused upon the behavior of staff rather than the individual. For example, step one stated that staff were to obtain a toothbrush and have the individual pick it up, without any indication of what behaviors comprised picking up the toothbrush. A later step stated that the individual was to "brush the outer bottom surface of his teeth". It was not clear what constituted brushing the outer bottom surface of his teeth. In the SAP, there was no indication of the specific characteristics of the behavior to be performed, such as the duration he was to brush his teeth or the amount of contact with the teeth that was required to constitute brushing. The lack of specifics suggested that a careful and individualized task analysis had not been completed. • For Individual #783, a SAP was provided to teach "independence in purchasing objects of her choice." The SAP included three steps; Give money to sales person, pay for items, and get change. The first two steps essentially required the same behavior. Furthermore, it was not evident what skills were being taught or had been the target of the task analysis. <u>Behavioral objectives</u> It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. In addition, objective statements must reflect the skill that is taught. If goals cannot be observed or measured, or involve behaviors other than those addressed in the training procedure, it is typically difficult to determine when an individual has achieved progress. Five of the 14 SAPs reviewed (36%) reflected adequate objectives. Examples of SAPs that did not reflect adequate objective statements included the following. • For Individual #276, the objective stated that the individual would apply hand-sanitizer. The training instructions, however, involved the individual tolerating the application of hand-sanitizer by staff. Although both behaviors were related to	

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		hygiene, both involved different skills. • Individual #726 was provided with an SAP to teach her to throw a ball to staff or peers. No criteria described what specific behavior would satisfy the objective of throwing to a specific person (or even if simply throwing, rather than throwing toward a person, was considered as meeting the definition for a successful throw). The lack of criteria was especially important, as the individual was blind and was likely to experience greater difficulty in performing the task than a sighted person. <u>Operational definitions</u> In order for training programs to be implemented correctly, it is imperative that the program specifically defines the behavior to be increased. This requirement informs the person implementing the program exactly what behavior the individual is expected to display. Without an operational definition, the risk of strengthening unintended behaviors and slowing the individual's acquisition of skills is increased, since different trainers may prompt and reinforce different behaviors rather than have a consistent requirement. Five of the 14 SAPs reviewed (36%) reflected adequate operational definitions. Examples of SAPs that did not reflect adequate definitions included the following. • Individual #42 was provided a SAP to strengthen tolerance of a suction toothbrush and having his teeth brushed using the suction toothbrush. The initial step provided a specific definition of the behavior, holding the toothbrush for 10 seconds with the power turned off. Later steps were less specific. For example, step four stated only that the individual would allow staff to brush the top teeth; there was no indication of the duration the individual was to display tolerance or the behaviors that would or would not constitute successful tolerance. • Individual #742 was provided a SAP to teach the selection of a preferred food item. The operational definition of the single step in the program stated that staff were to present pictures of food items to the individual and to ask the individual to identify a healthy food item. This was not an adequate operational definition, as the statement focused entirely upon what staff would do rather than what behavior the individual was to perform. In addition, the definition provided did not match the stated objective of the program. • Individual #766 was provided an SAP for using the telephone. The generalization strategy in the SAP stated only that, "When [the individual] dials the campus operator, he will practice communication skills". <u>Description of teaching conditions</u> In order for teaching programs to be implemented consistently as intended, the staff implementing those programs must be given explicit instructions including what materials are to be used, how those materials are to be arranged, where training should be conducted	

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		and how the environment should be controlled. Without such instructions, training conditions often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. Three of the 14 SAPs reviewed (21%) reflected an adequate description of teaching conditions Examples of where SAPs did not reflect adequate teaching conditions included the following. • Individual #726, who is blind, was provided an SAP to teach her to throw a ball to staff or peers. Teaching such a skill to someone who lacks vision requires that the environment be arranged to facilitate orientation. For example, the individual must be able to locate the person to whom the ball will be thrown, determine the distance to the target, and identify other persons or hazards in the area. In addition, conditions should allow for the safety of other individuals in close proximity to the training area. The SAP did not include instructions that reflected attention to these issues. <u>Sufficient trials</u> It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities for reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not compete effectively and efficiently with other reinforcement in the environment. Only one of the 14 SAPs (7%) included an adequate number of trials. In the majority of SAPs, less than an average of one training trial per day was scheduled. <u>Relevant discriminative stimuli</u> In order for training to be effective, there must be a cue or indication for the learner that reinforcement is available for the completion of a specific task. In the majority of reviewed SAPs, conditions were described in the SAP that could have served as a discriminative stimulus. For an event actually to serve as a discriminative stimulus, however, an SAP must be based upon careful assessment of the individual and the training methodology must be conducted with consistency. Eleven of the 14 SAPs in the sample (79%) included clear and specific cues that could serve as a discriminative stimulus. Examples of SAPs that did not include adequate discriminative stimuli included the following. • Individual #13 was provided a SAP to strengthen walking. Although the objective of the program indicated that a verbal cue was to serve as the discriminative	

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		stimulus, the staff instructions did not indicate the use of the verbal cue. <u>Specific instructions</u> As with the teaching conditions, it is necessary that training be conducted in a consistent and specific manner. Without specific instructions, the trainer may use a different prompt than was intended, offer reinforcement in a different way, or strengthen a behavior other than the behavior to be learned. Three of the 14 SAPs in the sample (21%) included adequate instructions for staff. In many of the other reviewed SAPs, the instructions were often vague or included for only some aspects of the SAP. Examples of SAPs that did not include adequate instructions included the following. • Individual #42 was provided a SAP to strengthen tolerance of a suction toothbrush and having his teeth brushed using the suction toothbrush. The initial step provided clear instructions for implementing the program, including the presentation of the toothbrush and time criteria for success. Later steps were less specific. For example, step four stated that staff were to brush the individual's top teeth; there was no specific instructions for how this was to be conducted. How staff were to brush teeth was important, as the goal was to increase the individual's tolerance for tooth brushing. Such a process often requires gradually increasing the duration or intensity of the activity the individual is to tolerate. Without specific instructions, some staff might brush gently for 30 seconds while other staff could use more pressure and brush for 90 seconds or more. As a result, the individual might require substantially longer training to achieve tolerance or even not learn to tolerate the procedure at all. • Individual #276 had at least three different SAPs involving some aspect of washing hands. All three programs were being implemented but each involved a different training strategy. There was no indication that the three SAPs were part of a multiple baseline or generalization strategy. Due to the multiple sets of implementation instructions, it was likely that the individual and program implementers could become confused about the expectations of the SAPs. <u>Specific consequences for correct and incorrect responses</u> For behaviors to be acquired and strengthened, it is essential that the person experience reinforcing stimuli as soon after the display of the behavior as possible. It is also crucial that these reinforcing consequences involve stimuli that are more powerful and efficient than reinforcing stimuli obtained for incorrect responses. It is therefore equally important that consequences for incorrect responses minimize reinforcing properties. To fulfill these requirements, a skill acquisition program must be based upon careful assessment, reflect specific reinforcing stimuli, clearly identify those behaviors that are to be reinforced as part of the teaching process, and provide instructions for how to avoid reinforcing incorrect	

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		responses. As noted previously in this provision, there were indications that SAPs were not based upon careful and comprehensive assessment. It was therefore difficult to know whether reinforcers included in the SAPs in fact held the potential for strengthening targeted behaviors. Furthermore, in several SAPs, the lack of detailed definitions of the target behavior increased the probability of incorrect delivery of consequences, thereby reducing the probability of individuals learning from the SAPs. As a result, the review of the 14 SAPs in the sample revealed that skill acquisition programs often lacked specific consequences for correct and incorrect responses. • Four of 14 SAPs in the sample (29%) included specific consequences for correct responses. • Nine of 14 SAPs in the sample (64%) included specific consequences for incorrect responses. Examples of SAPs that lacked specific consequences included the following. • For Individual #119, the SAP indicated the reinforcement was to be delivered, "When the individual responds to training". The term *responds to training* could mean a variety of different things, including touching the materials without performing the expected behavior or telling the trainer "no". It was therefore unlikely that staff would be able to identify when to deliver a reinforcing stimulus, thereby preventing a specific consequence for a correct response. • Individual #783 was provided a SAP for making purchases. Rather than identify the appropriate consequence for a correct response, the SAP indicated only the definition of a correct response. A vague consequence for refusal to participate was provided (Encourage her to tell you what she will do), but no specific consequences for incorrect responses were provided. <u>Documentation methodology</u> In order to determine if a skill acquisition program was successful, there must be a valid and reliable method of measuring and documenting the performance of the person being taught. This includes ensuring that teaching data are collected correctly and promptly. In some of the reviewed SAPs, the documentation process for skill acquisition data was absent or not clearly described. For example, the SAP for Individual #766 included no instructions for documentation. For Individual #783, specific documentation instructions were provided only for a successful display of the behavior. In several more SAPs, due to weaknesses in staff instructions, target definitions, or teaching procedures, it was not likely that documentation was valid or reliable. As a result, only four of the 14 SAPs in the sample (29%) included adequate documentation.	

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		Plan for maintenance and generalization Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the teaching setting. If an individual learns to differentiate colors in the classroom, but does not exhibit that same skill at home or at work or as part of a new and more complex task being learned, then the training has not been fully successful. In order to determine if skills are being used beyond the training setting, it is important that a specific method for monitoring the skill be in place. In addition, a specific strategy for strengthening the desired behavior in settings beyond the initial training environment must be included in the SAP. Six of the 14 SAPs in the sample (43%) included adequate maintenance and generalization strategies. In the remaining eight SAPs, proposed strategies for maintenance and generalization often involved nonspecific statements about encouraging the behavior in other places or at other times. Examples of SAPs that did not involve adequate maintenance and generalization included the following. • Individual #766 was provided an SAP for using the telephone. The generalization strategy in the SAP stated only that, "When [the individual] dials the campus operator, he will practice communication skills". The maintenance strategy included only the statement, "Ensure [the individual] will have the opportunity to increase independence and promote family contact. • Individual #783 was provided a SAP for making purchases. The generalization strategy stated only that the individual "will replicate the training anywhere with anyone". The maintenance strategy in the SAP stated only to "Ensure [the individual] continues to maintain the skill by continuing to provide her opportunity to use the skills". Although skill acquisition programs at DSSLC reflected necessary improvement, it was not evident that those programs were based upon adequate assessment. It was also frequently noted that SAPs lacked several of the components essential for learning. Therefore, it was not evident that skill acquisition programs promoted growth, development, and independence for individuals living at the Facility. Implementation of formal and informal skill acquisition training Historical Perspective During all previous site visits, pervasive problems were noted regarding the implementation of skill acquisition programs. Only in very limited circumstances had staff been observed to implement formal training or offer prompts and reinforcement in the manner prescribed by the skill acquisition programs. During the 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	

#	Provision	Assessment of Status	Compliance

meals and small classrooms. In several settings, however, staff was notably unfamiliar with individuals and training programs. In other settings, the lack of active treatment placed some individuals at risk of personal harm.

During the 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.

Data from the October 2012 site visit indicated 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 since the previous compliance visit, returning to levels found during the September 2011 visit.

Current Site Visit

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
528B	2	4	2	50%
528D	5	3	3	100%
527A	2	8	2	25%
527C	3	8	5	63%
508A	3	10	1	10%
ICD120	3	2	2	100%
ICD124	1	5	3	60%
ICD128	9	16	16	100%
ICD121	3	4	2	50%
508A	4	11	0	0%
508C	5	10	0	0%
523A	1	4	2	50%
523D	1	4	1	25%

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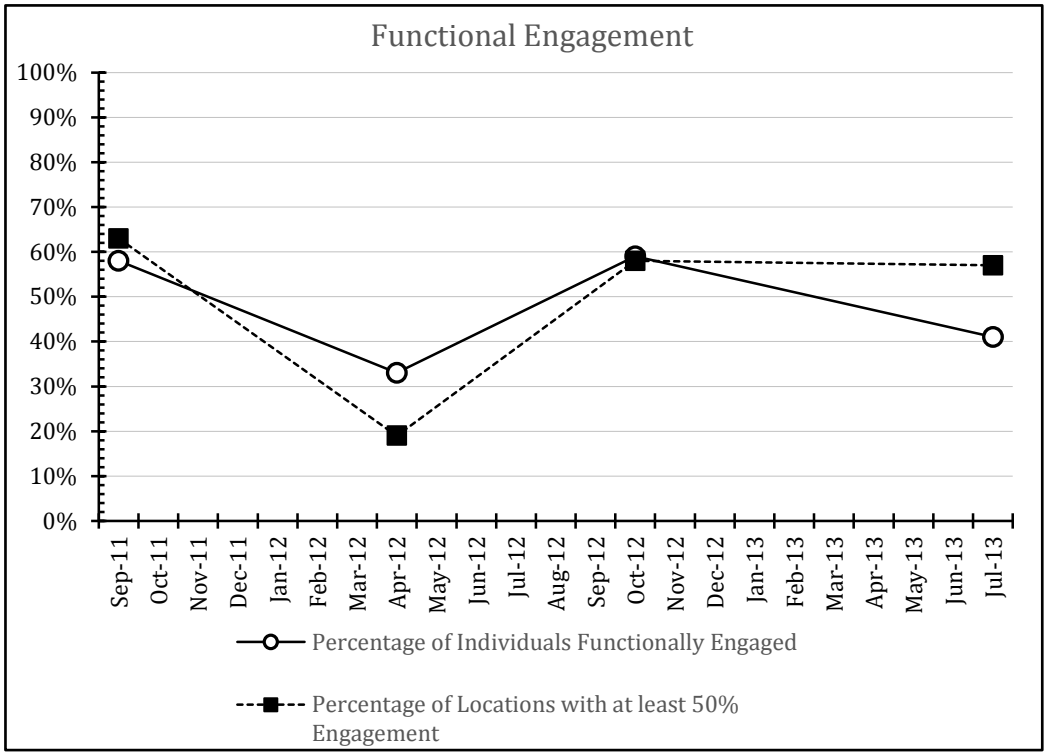
525A	2	5	0	0%
Total percentage of individuals functionally engaged				41%
Percentage of locations with at least 50% functional engagement				57%

Based upon the observations conducted during the current site visit, it was evident that overall functional engagement had decreased from 59% to 41% of individuals. Observations did reflect that eight of the 14 observed locations (57%) reflected functional engagement for at least 50% of the individuals present during the observation. Longitudinal data involving functional engagement is presented in the graph below.



As noted in the 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

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		hair and clothing to prompt color recognition. Individuals were noted to be very comfortable with staff, and often engaged in playful repartee. • In Apartment 528, during lunch staff were observed to provide frequent prompts to follow dining plans, as well as social conversation. Staff were also noted to prompt an individual to communicate successfully via sign language. Despite improvements noted in functional engagement in some locations, there were places at the Facility where the lack of functional engagement was concerning. In some residences, the lack of functional engagement appeared to place individuals at risk of personal harm. • During lunch at apartment 527, one individual was observed to be agitated. She cried loudly for several minutes. Throughout the crying, the individual had a large amount of food in her mouth, held her mouth open widely, and tilted her head backwards. Even though the individual's dining card reflected there was a risk of choking and aspiration, and her posture increased the risk of choking upon or aspirating the food in her mouth, staff did not intervene or monitor her status. • During dinner at apartment 508, the environment could be described as greatly disorganized. None of the individuals dining was positioned correctly and no staff were observed following dining plans. The individuals not dining were observed to engage in impulsive behaviors such as striking at staff, crawling about the floor on their hands and knees, and scuffling with peers over the few materials in the environment. Staff were not observed to interrupt undesired behaviors or organize structured activities. The few communication devices in the apartment were placed in locations that individuals not reach, including behind an oscillating fan. In addition to observing functional engagement, SAP data were reviewed in each of the 14 locations in which observations were conducted. Data forms for a total of 26 SAPs were reviewed to determine if the appropriate data collection forms were present, if information about the individual (Name, ID number, etc.) was correctly presented on the data form, if data were current up to the time of the observation, and if data were recorded according to instructions on the SAP. The review process revealed the following. • Twenty-six of 26 SAPs (100%) had the correct data collection forms • Nineteen of 26 data collection forms (73%) correctly included all individual information • Nine of 26 data collection forms (35%) were current up to the time of the review • Fourteen of 26 data collection forms (54%) reflected data recording that conformed with SAP instructions Based upon observations and record reviews, there were indications that the Facility had achieved progress in relation to the components of the SAPs. It was not fully possible to assess the integration of assessment data into the ISP and SAP development process, due to	

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		a lack of records. The records that were available, however, suggested that considerable weaknesses existed in the conducting of assessments and utilizing assessment data in the development of SAPs. There were also indications that SAPs were not always implemented or documented according to instructions in the SAPs. Overall, the information obtained reflected that the Facility had yet to achieve substantial compliance with the Settlement Agreement.	
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> 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. 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. During the October 2012 site visit, DSSLC was asked to provide an example from each of the five 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. <u>Current Site Visit</u> Information concerning Psychological Assessments is provided in the report for Provisions K.5, K.6, and K.7; none of those three Provisions was found to be in substantial compliance. The Facility provided additional information regarding the timeliness of all evaluations submitted for the ISP between October 2012 and May 2013. This information is presented below.	Noncompliance

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	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Total Average
Life Skills	83%	96%	100%	96%	90%	92%	96%	92%	93%
Audiology	95%	100%	95%	92%	94%	89%	98%	100%	95%
OT/PT	87%	89%	88%	85%	85%	66%	84%	91%	84%
Vocational	100%	100%	100%	89%	93%	80%	84%	89%	92%
SAM	91%	90%	85%	64%	75%	86%	70%	81%	80%
Speech	68%	68%	55%	59%	45%	65%	74%	67%	63%
Dental	95%	87%	91%	36%	91%	97%	97%	88%	85%
Pharmacy	77%	98%	100%	97%	100%	100%	100%	100%	97%
Psych	89%	72%	63%	55%	62%	61%	75%	62%	67%
Medical	67%	56%	66%	48%	51%	72%	75%	75%	64%
FSA	69%	44%	51%	53%	72%	73%	80%	78%	65%
Nursing	87%	85%	85%	69%	73%	88%	82%	83%	82%
Average Percentage Across Disciplines	84%	82%	82%	70%	78%	81%	85%	84%	

None of the 12 disciplines included in the review had submitted all evaluations on time for each month. Vocational Services had achieved 100% of reports on time for the first three months, but then dropped to 89% on time by May 2013. The Pharmacy department, however, achieved 100% compliance for five of the eight months reviewed. Overall, four of the 12 disciplines (33%) averaged less than 70% compliance with time requirements over the eight months.

Based upon this information, as well as weaknesses noted in Provision S.1, the Facility had not met the requirements for substantial compliance concerning this Provision.

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,		

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	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. A SAP would be practical and functional if it a) could be implemented in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed. In order to address the issues of being practical and functional, the Facility reported that an auditing protocol and process was implemented for SAPs. Including in the auditing process were four questions; 1) Was there evidence that each SAP was monitored monthly to determine the progress of the individual, 2) Were data used in making decisions about continuing or revising SAPs, 3) Were data collected as scheduled, and 4) Were data collected correctly. In addition, a sample of SAPs were reviewed by a BCBA. The review process established by DSSLC addressed issues important to any teaching program. In addition, it was obvious that the Facility had invested considerable time and effort in developing and implementing the SAP review process. Overall, the effort provided valuable information about the quality of the SAPs as well as the manner in which SAPs were implemented and monitored. Despite the effort involved and the information obtained, it was not evident that the review process addressed the issues of SAPs being practical and functional. Documentation did not reflect that a system was used to identify SAPs that were appropriate or practical for the locations in which training was to be conducted. Some of the SAPs submitted by the Facility did address such needs as vocational skills that were to be taught at the job site. There did not appear to be a mechanism, however, that ensured all SAPs were practical. For Individual #276, the objective stated that the individual would apply hand-sanitizer. Although the SAP could be implemented in various locations, it was not specified in the plan how to ensure that sanitizer was to be made available. • Individual #726, who is blind, was provided an SAP to teach her to throw a ball to staff or peers. It was not specified in the program how the various teaching locations could be organized to both facilitate training and ensure the safety of all participants. To determine whether a proposed skill acquisition program is functional for an individual, it is critical that the program author and interdisciplinary team members have a precise	Noncompliance

#	Provision	Assessment of Status	Compliance
		understanding of the individual's needs and abilities. As noted previously in Section S, only a small number of SAPs were submitted with the ISP documentation and assessment reports. This prevented a full appraisal of the ISP and assessment process. Even in the materials that were made available, substantial weaknesses were noted in the assessments. As a result, it was suggested that it would be difficult to determine for many individuals whether a SAP was functional. Based upon the information submitted by DSSLC, despite the considerable effort put forth by the Facility, there was no indication that the Facility had achieved substantial compliance for this Provision.	
	(b) Include to the degree practicable training opportunities in community settings.	<u>Historical Perspective</u> At the time of the March 2011 site visit, DSSLC had generally increased the total number of community activities compared with the same period 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. In October 2012, the Facility reported 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. <u>Current Site Visit</u> During the current site visit, the Facility reported that the emphasis upon training during outings had continued since the previous site visit. The graph below depicts the reported change in emphasis and the resulting increase in community SAPs.	Noncompliance

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		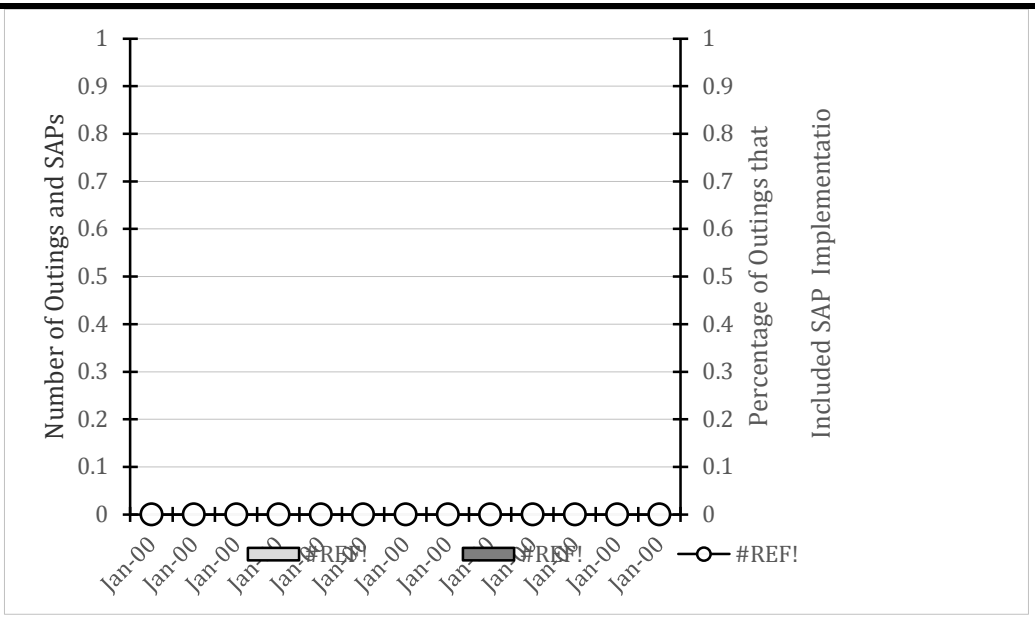 DSSLC collected and presented an abundance of information regarding skill acquisition programs, community outings, and the details of many of the hundreds of reported outings. Due to the weaknesses noted in the assessment for and development of skill acquisition programs, however, it was not possible to determine if the quality of the SAPs and training was commensurate with the quantity. 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 October 2012 site visit, the number of individuals in competitive employment had increased to nine. During the current site visit, that number had dropped to eight once again.	

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Documents Reviewed: 1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 7/8/2013 2. Denton State Supported Living Center Action Plans, updated 6/21/2013 3. Denton State Supported Living Center Report for Monitors 4. Section T Presentation Book materials 5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10 6. DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, dated May 22, 2013 7. DSSLC Policy CMGMT 39.a: Exhibit I: Pre-Placement Medical Chart QA Protocol, dated 3/20/13 8. DSSLC Policy CMGMT 39.a: Exhibit J: Pre-Placement Doctor to Doctor Contact Protocol, dated 3/20/13 9. DSSLC Policy CMGMT 39.a: Exhibit K: Increasing Individual's Participation at Their Own ISP Meeting, dated 5/17/13 10. Plan to Support People to Live in the Most Integrated Setting of Their Choice, undated 11. Draft of DADS Policy 004.1: Individual Support Plan Process, dated 11/20/2012 12. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 13. Since last on-site review, a list of all individuals who have been referred for placement 14. 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" 15. Since last on-site review, a list of all individuals who have died after moving to community living 16. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 17. For the last twelve months, a list of individuals who were reported to have been assessed for placement 18. Community Referral Activities/Status List, undated 19. Community Placement Report (CPR), dated 7/22/13 20. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #45, #64, #92, #125, #152, #242, #290, #478, #590, and #629 21. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 22. DSSLC Newsletter, The Grapevine, dated February 2013 23. Annual Report: Obstacles to Community Transition, Fiscal Year 2012, prepared November 2012 24. Analysis of Obstacles, dated March 2013 25. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 26. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #45, #64, #92, #125, #152, #242, #290, #478, #590 and #629 27. Individual Support Plans (ISPs), ISP assessments and Preferences and Strengths Inventory (PSI) for Individuals #42, #231, #288, #317, #490, #567, #667, #772, and #788

	28. Denton State Supported Living Center Community Tour Documentation form 29. Completed CLDPs for Individuals #133, #385, #359, #476, and #763 30. Partial CLDPs for Individuals #22, #194, #306, #691, and #753 31. CLDP Assessment Checklist, undated 32. CLDP Helpful Hints, undated 33. Pre Move Site Reviews for Individuals #67, #81, #122, #133, #217, #229, #232, #265, #359, #385, #476, and #763 34. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals 35. Post-Move Monitoring Checklist, revised May 2013 36. PMM Helpful Hints, undated 37. Completed Post Move Monitoring (PMM) checklists for Individuals #67, #81, #122, #183, #232, #265, #291, #359, #385, #476, and #763 38. Integrated ISP Monitoring Tool **People Interviewed:** 1. Clark Clermont, Director of Community and Family Relations (CFR) 2. Leslie Clark, QDDP Coordinator 3. Jodi Vicars-Nance, Admissions/Transition Coordinator (ATC) 4. Tawasky Jones, Placement Coordinator 5. Laurie Cross, Post-Move Monitor 6. Lori Powell, Quality Assurance (QA)Director 7. Eileen Short, Transition Specialist Coordinator 8. Sarah Ciccia, Transition Specialist 9. Frank Padia, Facilitator Coordinator 10. Marty Mapp, Lead QIDP **Meeting Attended/Observations:** 1. Annual ISP meetings for Individuals #231 and #667 2. ISP Preparation meeting for Individual #608 3. Post-Move Monitoring Visit for Individual #133 4. Referral Review Committee
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. 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. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The self-assessment rating relied to a large extent on data collected through the Facility's QA/QI processes, including the Integrated ISP Monitoring Tool. The Facility also reported it had identified a need for a new Community Living Discharge Plan Audit that identified key risks, preferences, community integration needs, accessibility and support needs and equipment needs, which would evaluate whether these were adequately addressed in the CLDP. There were no data provided as to the implementation of this audit at this time, as it was a new process to

	be implemented. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. This would change the focus of the Action Plans from measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. **For Provision T1**, the Facility indicated it was not in full compliance with his provision, but it did report it had achieved some level of compliance for the following provisions: T1b2, which requires the Facility to ensure adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices; T1c2 which requires the Facility to specify the SSLC staff responsible for CLDP actions, and the timeframes in which such actions are to be completed; T1c3, which requires the CLDP to be reviewed with the individual, and LAR as appropriate, to facilitate their decision-making; T1e, which requires the Facility to verify essential supports are in place prior to an individuals' transition to the community; T1g, which requires the Facility and DADS to gather, analyze and take appropriate actions related to individuals' movement to the most integrated setting; and T1h, the issuance of the Community Placement Report. The Monitoring Team concurred with Facility findings of both substantial compliance and noncompliance for T1c2, T1c3, and T1h, but did not concur for T1b2, T1e or T1g. **For Provision T2**, the Facility self-rated substantial compliance in Provision T2a due to timely completion of all PMM visits and reports, maintaining adequate documentation and undertaking follow-up in a timely manner. 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. . **For Provision T3,** no compliance rating is required. **For Provision T4,** the Facility indicated it remained in substantial compliance, although no alternate discharges had taken place in the last six months. This was based on a previous compliance rating and no changes in the process having been made. The Monitoring Team concurred but did not rate this provision as there were no alternate discharges.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. A summary of noted progress included a sizeable increase in the number of referrals for transition and an emphasis on developing individualized community awareness plans to assist individuals to form their preferences about community living. The Facility had also drafted a one-page Plan to Support People to Live in the Most Integrated Setting of Their Choice, which provided additional detail as to the roles and responsibilities of the various staff. Progress was noted in implementation of the CLDP processes, including the addition of two new practices including a Pre-Placement Medical Chart QA Protocol, and a Pre-Placement Doctor to Doctor Contact Protocol. These

	practices were designed to ensure that medical and health care issues were adequately identified prior to transition and adequately communicated to the community living providers. The Monitoring Team found there was progress in the implementation of the ISP process, particularly in one of the on-site ISP annual planning meetings, but significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning. Other specific findings are detailed below: **For Provision T1**, fifteen individuals had transitioned to community living and there were 39 active referrals. The Monitoring Team did find substantial compliance in several sub provisions, T1c2, T1c3 and T1h. Respectively, these addressed the identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed; review of the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living; and, the issuance of the Community Placement Report. Despite the strides referenced in the Summary of Monitor's Assessment above, 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 its efforts toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. The IDT also often 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 continued to be apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. **For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. 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. Given the volume of referrals and expected transitions, such deficiencies in the process are likely to become magnified if not resolved. **For Provision T3**, no rating is required. **For Provision T4**, the Facility was not rated. The Facility reported no Alternate Discharges during the past six months.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-	<u>Transition Outcomes During Last Six Months:</u>	Noncompliance

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	ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	• Community Transitions: The number of community transitions showed a stable or increasing trend. o There were 15 transitions to community living in the last six months. With 484 individuals currently living at DSSLC, this represents approximately three percent of the population. This figure was a sizeable increase over previous monitoring periods for which nine individuals had transitioned during each six-month period. o The transition process took more than 180 days for ten of the 15 (67%) individuals. • Referrals for Community Transitions: o The number of community referrals indicated a significantly increasing trend. Twenty-eight referrals had been made in the past six months, according to the Community Placement Report. o Thirty-nine individuals were on the active referral list (approximately eight percent of the current population at DSSLC). o Twelve of the 39 (31%) individuals had been on the referral list more than 180 days; only two had been on the list for more than one year. • Individuals requesting placement, but were not referred: Of the six individuals who requested placement during this six months, but were not referred, four (67%) had an LAR who made this decision. • Rescinded Referrals: o There were six rescinded referrals reported since the last review. o Of these, the reasons for the rescinding appeared to be well-documented by the IDT for all six (100%). Two rescissions were as the result of LAR choice, two were related to medical and/or psychiatric issues, and two were noted to be individual choice. o There did not appear to be cause for any review to be conducted to determine if changes in the referral and transition planning processes were needed at the Facility. • Returns from Community Placement o No individuals had returned from a community placement. This number of individuals who returned to the SSLC after a failed community placement indicated a stable trend over the previous two monitoring site visits. • Deaths Following Community Placement o Since the last onsite review, there had been no deaths of individuals who had moved from DSSLC to the community. One death, detailed in the last monitoring report had occurred in last 12 months. • Other Adverse or Unexpected Outcomes • Between 6/1/12 and 6/1/13, two of the 16 (13%) individuals who	

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		transitioned had experienced one or more other untoward events since placement. Of these, there was documentation provided of an adequate review conducted for one (50%) of the cases to determine if changes in the referral and transition planning processes at the Facility should be made. <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u> During this past six months, DSSLC had taken a number of steps that were intended 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. It appeared these steps were leading to improved outcomes in terms of the numbers of individuals who had been referred for transition to community living and the length of time required to locate an appropriate home and effect a safe move. Several of the positive practices included: • Either the ATC or the Placement Coordinator was designated to take the lead on an individual's referrals. In addition, one of two Transition Specialists funded by the state's Money Follows the Person (MFP) program was assigned to each individual referred to assist in identifying appropriate settings, arranging for tours and interfacing with the respective IDT to ensure the individual's response to tours and trial visits were being adequately evaluated. • A Referral Review Committee met on a weekly basis to review the status of referrals as well as results of post-move monitoring. The Committee was comprised of the Director of CFR, the ATC, the Placement Coordinator, the two Transition Specialists, the Transition Specialist Coordinator (a statewide position housed at DSSLC), and the Post-Move Monitor. The group reviewed a tracking database, made any additions needed, discussed issues and problem-solved as needed. The Monitoring Team participated in one such meeting and commends the Facility for its careful attention to detail evidenced during this meeting and in the related documentation. This will be even more important in the coming months with the volume of current referrals and moves that will take place. • The Department of CFR had developed a one-page Plan to Support People to Live in the Most Integrated Setting of Their Choice, which provided additional detail as to the roles and responsibilities of the various staff. • The Director of CFR attended the Integrated Morning Report (IMR) meeting daily; once per week, he reported on the status of referrals and updated the members on post-move monitoring outcomes. He reported this information was well-received and appeared to make those participating more aware of	

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		and open to the transition process. a. New policy enhancements were added to local policy to enhance the transition planning process including a Pre-Placement Medical Chart QA Protocol, a Pre-Placement Doctor to Doctor Contact Protocol and Increasing Individual's Participation at Their Own ISP Meeting. These are discussed in more detail in this Section below. Conclusion: There was progress in this area, but the provision was found to be not yet in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (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 policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	Policies and Procedures related to transition and discharge processes: At parties' meetings in July 2012, the parties agreed that the Monitors would rate Provision T1b as just the development of an adequate policy. The subsections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of Provision T1b or any of the other cells under Provision T1b. The Facility reported that it had made no changes to transition and discharge policies. There was a pending revision of DADS Policy 018, particularly related to the modified requirements for the CLDP and PMM, which is expected to also require modifications to local policies. As 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.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs	Protections, services, and supports: DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in Section F of this report, substantial compliance was not found for Provisions F1d, F2a1, and F2a3. As documented in Provisions F1d, F2a1 and F2a3, the Monitoring Team found the IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting. Therefore, substantial compliance was not found for Provision T1b1. Identification of and Plans to Overcome Obstacles to Transition: DSSLC reported it gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles. These included:	Noncompliance

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	and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	• Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Lack of supports for people with significant challenging behaviors • Lack of availability of specialized therapy supports • Lack of availability of specialized medical supports • Lack of funding due to an individual's legal and citizenship status • Lack of specialized mental health supports • Need for environmental modifications to support the individual • Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual Of the nine ISPs reviewed, the Monitoring Team found that eight should have had obstacles defined (the other individual was referred for transition to the community). Of these eight ISPs, none (0%) included an adequate list of obstacles to referral and obstacles to transition. Plans to address obstacles at the individual level were also not adequate. Of the eight ISPs for non-referred individuals, none (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). For Individual #231, the Monitoring Team found there was some progress in the IDT's approach to addressing obstacles. There was some discussion with the individual's brother, regarding the individual's preferences for remaining at the Facility, but no substantive discussion about the nature of those preferences. This was particularly unfortunate, as the individual is very verbal and should have been able to describe an "ideal" living situation if someone had worked with him over a period of time, as well as to describe the concerns he had about community living. This information could have been used to clarify the obstacle and develop a targeted plan. This was compounded by two other factors. First, the LA reported not being able to draw much from the CLOIP interview because the individual was anxious to get back to work. Again, if this interview were done at a time convenient for the individual, and in a manner conducive to his needs, it appeared he had the verbal and cognitive skills to actively participate. Finally, the brother stated the individual could stay at DSSLC if that was his preference, but that he was not opposed to considering community living options. The eventual Action Plans developed included invitations to provider fairs and participation in the CLOIP process annually. It also included the creation of "anchors" in the community, which referred largely to being involved in community activities, but it was not clearly defined how these anchors were intended to address the obstacle, which	

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		remained largely undefined. For example, one Action Plan was for the individual to attend a Self-Advocacy meeting in the community by 10/13. There was no discussion as to how this might address the community living obstacle; in fact, it might well serve to do so, but since there was no discussion of the individual's actual concerns about community living, it would have been hard to define how this would address them. The Monitoring Team commends the IDT for its efforts and encourages it to re-examine and clarify the purposes of these strategies as they relate to the specific nature of the obstacle. <u>Preferences of Individuals and LARs</u> Of eight completed ISPs for which a referral had not been made, none (0%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). For the most part the documentation indicated the individual's preference was unknown. In one of two annual ISP meetings observed and final ISPs reviewed, a referral was made and the IDT had a thorough discussion of the individual's preference for where to live. The Facility had developed and was implementing a plan to address issues related to the unknown preferences of individuals. The Facility provided a document entitled Analysis of Obstacles, dated March 2013. This report isolated the issue of individual's reluctance for community placement. It was noted this was a broad category and research was undertaken to clarify reasons for this reluctance. A review of ISPs indicated that the largest group was made up of individuals who did not have sufficient awareness to indicate a preference. As a result, an Action Plan was developed to provide community exposure for these individuals through enhanced CLOIP activity and the services of the Transition Specialists and CFR staff. These staff were to accompany individuals on tours and bring back information to the IDTs for the next ISP. In addition, the Director of CFR had also undertaken to review every Preferences and Strengths Inventory (PSI) to identify individuals with unknown preferences in this area, with the intent of assigning a Transition Specialist to attend the ISP meeting and offer technical assistance to the IDT. It was noted that at least one such individual, Individual #667, was referred for transition during the monitoring visit. This was a thoughtful and commendable approach to addressing the issue of individual's preferences and should be seen as one important component of an individualized community awareness and education plan as recommended in Provision T1b2 below. Preferences of LARs and families for living arrangement were typically more often understood and documented. The Facility was providing some opportunities for families	

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		and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. The annual ISP process typically did not lend itself to a comfortable discussion of community living opportunities, as described in Provision F1e. Conclusion: This provision was found to be not in compliance.	
	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: 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: An Individualized Plan For Each Individual: The Facility was making progress toward developing individualized plans for community education and awareness. There was no significant progress observed in the sample of eight recent ISPs reviewed for which a referral had not been made. 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 eight (0%) ISPs for which a referral had not been made was there an adequate individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. An Annual Provider Fair: The Facility had held a second semi-annual provider fair since the previous monitoring visit, on 3/16/13. This event was held on a weekend to facilitate the participation of individuals and LARs who might be unable to attend on weekdays due to work and other obligations. Participation was significantly lower overall than the weekday fair held in September 2012, including for individuals and staff, but about the same for families and LARs. The Facility continued to complete a survey of the participants in the fairs and use these data to vary its approaches to this activity. For example, the recent survey data indicated providers would benefit from training in positive behavior support and the Facility is planning to incorporate this into the next fair event. The Facility also shared the analysis of the date with the LAs. Regular SSLC Meeting With Local LAs: The Director of CFR reported DSSLC staff continued to have joint Interagency Planning Meetings with local LAs to coordinate admissions and discharges as well as to jointly plan for education about community living options. Education About Community Options: 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	Noncompliance

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		outcomes. Examples included: • IDT Action Plans: DSSLC was not yet collecting data regarding the development and implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should consider developing a process to do so. • 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 ten CLOIP Worksheets for recent ISPs. For these individuals, three of ten (30%) were allowed by the LAR to participate in the CLOIP. For one of the three (33%) 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 two reviewed, the LA Service Coordinator documented the individual did not seem to comprehend or attend to the material presented. This continued to indicate DADS needs to assess how the process, materials and/or information might be modified to more effectively meet the needs of the individuals. Tours Of Community Providers: There did not yet appear to be a consistent, formalized process in place at the Facility to fashion these provider tours as a part of an individualized community living awareness and education plan, although there was some progress noted as described below. Specific findings regarding community tours included: • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): In the past six months, the documentation provided by the Facility listed a total of 27 individuals, unduplicated, who had participated in community tours. 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 484 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in informed decision-making. Many of the 27 individuals who participated in tours were those who had an active referral at the time of the tour. The Monitoring Team was concerned that individuals who had not yet been referred were not being offered opportunities to explore community options, except on a very minimal basis, resulting in their having no experience on which to form any preferences. The Facility was aware of this concern and was developing a strategy to address it. • Places chosen to visit are based on individual's specific preferences, needs, etc.: An individualized education and awareness plan should define the types of	

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		settings to which an individual may need exposure to facilitate his or her understanding of community living options. There was not a yet consistent or formalized process described for choosing tour sites based on individual preferences and needs; however, there was progress noted in this regard. In addition to the Facility reporting the development of an overall approach to individualizing tours based on an individual's preferences and needs, the Monitoring Team did observe the IDT for Individual #667 make a thoughtful consideration of the individual's needs and how to integrate these into the design of the proposed tours. • 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. The size of tours at the Facility appeared to be conducive to both individual learning and assessment of responses. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. The Facility used a form entitled Denton State Supported Living Center Community Tour Documentation for staff to document the living option toured, a description of the home and a narrative regarding the individual and staff reactions and/or comments. Opportunities Are Provided To Visit Friends Who Live In The Community: No information was provided regarding opportunities for individuals living at the Facility to visit with friends who had moved to the community. Education Provided In Various Venues: The Facility did hold bimonthly self-advocacy meetings for adults and youth. A review of the minutes for the past six months reflected education about community living options was regularly included on the agenda. A Plan For Staff To Learn More About Community Options: The Facility indicated in its 2012 Annual Obstacle Report that it recognized staff education and awareness was a key component to reducing obstacles related to reluctance of the LAR and/or the individual. Educational opportunities about community options had been provided through staff participation in community tours, community exploration activities for individuals, and transition related visits. The Facility provided a list of staff (including some duplicates) participating in such activities since the last monitoring site visit, including tours and visits. Staff also had the opportunity to attend the Provider Fairs and the Facility documented 43 staff who took advantage of this event in March 2013. The Facility also offered the Annual LA in-service training on Community Living Options on 6/07/13, with	

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		60 staff attending. The Director of CFR stated it seemed that DSSLC staff were taking this opportunity to ask more specific questions, about such concerns as appropriateness for transition and the LA monitoring process. He believed this would support the continuing growth in referrals as well as the ability of the IDTs to make appropriate judgments about obstacles and available community services. The Director of CFR also conducted a session of new employee orientation on an ongoing basis that focused on topics related to the most integrated setting, including availability of community services, identifying and addressing obstacles to community living and post move monitoring and protections. Between 12/3/12 and 5/18/13 this reached 192 staff. On 5/24/13, the Department of CFR also provided training on community referrals and placements to the Habilitation Therapies Department. <u>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories:</u> The Transition Specialists had begun to develop written success stories about individuals who had transitioned and two examples were provided in the Presentation Book for review. At least one was published in the DSSLC newsletter, the Grapevine, in February 2013. They were well-written stories that could be helpful for individuals and families who were reluctant to visualize positive outcomes. The Monitoring Team again commends the facility for making good use of the Transition Specialist positions. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team commends the efforts and progress 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 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	<u>Percentage of Individuals Assessed as Required:</u> The Facility provided a list of 488 individuals entitled "Assessed for Placement Since 3/12/2012." It also provided the following description of it assesses individuals for placement:	Noncompliance

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	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.	"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." The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement. State and local policies require that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. In addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. Issues that affected the adequacy of the assessment included: • The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements as described in Provisions T1b2 and F1c. Plans to educate individuals as to community living options were not well-thought out, individualized or sufficient in scope in most instances. The Facility was devising strategies to address this issue. • As described in Provision T1b1, the IDTs continued to lack proficiency in	

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		identifying 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. • For the nine ISPs reviewed, there were a total of 72 discipline-specific assessments reviewed. Of these, 57 (79%) included a determination of whether the individual could be served in a less restrictive setting. • Of the 72 assessments reviewed, six (8%) included recommendations for how the individual's needs could be met in a more integrated setting. • In nine of the nine (100%) written ISPs reviewed, a statement of the opinion and recommendation of the IDT's professional members was included, and a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was also included. • The independent team statements of the facility disciplines documented in the ISPs were frequently inconsistent with the professional opinions the professionals provided in their individual assessments, however. The discipline assessments almost uniformly indicated the individual could be served in a less restrictive setting, but for only three of nine (33%) did the facility discipline members make an independent recommendation the individual would benefit from being served in the least restrictive environment. This is discussed in more detail in Provision F1e. • In only one of the nine (11%) written ISPs reviewed did a thorough discussion of living options occur (i.e., consideration of different types of community living settings, locations, preferences, safety needs, etc.) This was for the only individual in the sample who was referred. For the most part, the documentation in the ISPs indicated the IDTs were deferring to the description in the CLOIP report. <u>Conclusion:</u> This provision was found to be not in compliance.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	<u>CLDP Policy and Process</u>: The Department of CFR was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. DADS had issued a revision to the CLDP format (Form SSLC 018E, March 2013) which the Facility had begun using with the two most recent referrals. The revised format was condensed and closer to the original CLDP format used previously. The Facility had also added two new practices as exhibits to the related to the CLDP, entitled Pre-Placement Medical Chart QA Protocol, and the Pre-Placement Doctor to Doctor Contact Protocol, both dated 3/20/13. These practices were designed to ensure that medical and health care issues were adequately identified prior to transition and adequately communicated to the community living providers.	Noncompliance

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		Timeliness of Development and Implementation of CLDP: The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The Monitoring Team reviewed a sample of five completed and five CLDPs in progress for referrals made during the past six months. Overall, the Monitoring Team found that documentation was more frequent and more detailed once the Transition Specialists were designated to maintain the referral status updates, so this appeared to be a successful modification to the process: • Ten of the ten (100%) CLDPs were initiated within 10 calendar days of referral as required by policy. • Five of the five (100%) completed CLDPs included adequate documentation to show that they were updated throughout the transition planning process. • Two of five (40%) CLDPs in progress included adequate documentation to show that they were being updated throughout the transition planning process. The Monitoring Team also reviewed an updated Community Placement Report, updated on July 22, 2013, supplemented by the documentation from the Referral Review Committee meeting held on f 7/22/13. This latter document provided more accurate data regarding the actual initial referral date. • Eleven of the 39 (28%) current referrals had exceeded the 180 days allowed in the current policy and pending revision. • Ten of the 15 (66%) transitions that had occurred also exceeded 180 days. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. DADS policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. The Facility had also developed a Referral Review Committee, which formalized a weekly review process of existing referrals by the Department of CFR and the Transition Specialists. The Monitoring Team had the opportunity to observe this committee in action during the site visit and commends the Facility and the Department of CFR for implementation of this strategy. It appeared it was contributing to a more effective and timely process for transitions to occur. It appeared, however, that there was still sometimes a delay in initiating community exploration following the initial referral meeting or in sustaining that activity at a reasonable pace. For example, the Monitoring Team reviewed five CLDPs in process to evaluate whether the Facility was compliant with its policy to document transition activity on an ongoing basis. Only two of five (40%) CLDPs in progress did not evidence unexplained delays in meeting to select providers for pre-selection visits, scheduling pre-selection visits and/or reviewing the outcomes of pre-selection visits. For the most part,	

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		this issue appeared to be resolving, as noted above, as the Transition Specialists were integrated into the processes and began updating documentation routinely in May and June 2013. Only one of the CLDPs evidenced an unexplained delay since that time, in that the individual's profile was still under development close to a month after the referral was opened; all others had ample documentation of activity beginning in June 2013. The Facility is to be commended for this progress. The Facility should still consider ensuring that timeliness of actions related to referrals and community placements is included as a measure in its development of the quality assurance procedures required under Provision T1f. <u>Development of CLDP in coordination with the LA:</u> A review of completed CLDPs indicated that five of the five (100%) CLDPs included documentation to show that the facility worked collaboratively with the 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. <u>Conclusion:</u> Provision T1c was 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. There were still a number of instances in which placements did not occur within the 180-day requirement, which was sometimes related to a lack of timely action and follow-up by the IDT after a referral was made. The integration of the Transition Specialists appeared to be contributing to a timelier outcome for most individuals in recent months.	
	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.	None of five completed CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). Collaboration with community providers was typically limited to the doctor to doctor consultation. The Facility may want to consider how and under what circumstances this model may also be effectively applied in other disciplines. • Assessment of settings by SSLC clinicians (e.g., OT/PT) • Collaboration between provider day and residential staff is ensured • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community)	Noncompliance

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		• Collaboration between Post-Move Monitor and Local Authority staff None of the five CLDPs reviewed (0%) clearly identified a set of activities to occur on the day of the move, the responsible staff member, and documentation that the activities did indeed occur. Certain day of move activities were listed in the CLDP, but did not consistently document the responsible staff, nor was any day of move documentation provided with the CLDP. In some instances, the 7-Day Post-Move Monitoring did make note these activities had occurred. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	<u>Responsible staff identified for needed actions:</u> For five of five (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. <u>Completion timeframes for needed actions identified</u>: For five of five (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. <u>Conclusion:</u> 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.	<u>Evidence of individual/LAR participation:</u> Based on review of ten CLDPs, ten (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by signatures on the CLDP and narrative descriptions throughout the ongoing updates to the plan. <u>Conclusion:</u> This provision was found to be in substantial compliance.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	<u>Timeliness of Assessment:</u> 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. <u>Adequacy and Comprehensiveness of Assessments:</u> 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	Noncompliance

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		information the IDT and the community provider would need to develop an appropriate transition plan. 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. As described in Provision T1e below, in a review of five completed CLDPs, the Monitoring Team found that the assessments did not consistently address the full array of services and supports needed for each an individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, few of the assessments reviewed placed any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. There also continued to be discrepancies in assessments that were either not addressed or not resolved that found their way into the final CLDP, and recommendations within assessments that were not addressed. For example: • Individual #359 had had a significant weight loss over the past year. According to the Nutrition and Nursing Assessments, the weight at the time of the CLDP was 116.8 lbs., down from 150.6 a year before and from 130.5 just three months before. The physician summary at the time of the CLDP and an addendum just prior to the actual discharge date both indicated his weight was 146.2. The IDT progressively increased his caloric intake, but it was reported in the information reviewed that in spite of increasing calories the individual had lost weight every month except December 2012, until finally registering a two pound gain in June 2013, just prior to transition. There was no other action taken by the IDT to determine if there were any underlying causes for the weight loss. • These deficiencies continued to exist despite the newly implemented Pre-Placement Medical Chart QA Protocol in which an external physician reviewed the chart and the CLDP assessments. For example, the Pre-Placement Medical Chart QA for Individual #359 did not identify the discrepancy in the physician's recording of the inaccurate weight, but did note the weight loss and recommended continuing monitoring and diet modification to adjust weight loss. No recommendations were made for evaluating underlying causes. Conclusion: This provision was not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • Expand upon the initiative to ensure the CLDP provides an accurate and complete description of each individual's needs for services, protections and supports. This could include an interdisciplinary review of the CLDP assessments prior to the final CLDP meeting to ensure all important information	

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		is adequately captured, discrepancies are identified and resolved and supports are described in an integrated manner. As a side benefit, this process would also be valuable for each team toward enhancing its interdisciplinary skills overall.	
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.	<u>Identification of Pre and Post Move Supports</u>: In none of the five completed CLDPs reviewed (0%) was there identified a comprehensive set of pre and post move supports, in measurable/observable terms, to be implemented. This finding was based on an evaluation of presence or absence of each of the following criteria: • The list was comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. o All safety, medical, healthcare, risk, and supervision needs were addressed. o What was important to the individual was captured in the list of Pre and Post Move supports. o The list of supports thoroughly addressed the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of Pre and Post Move supports. o There were Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. o There were Pre and Post Move supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. o Topics included in training had a corresponding Pre and Post Move support for implementation. • The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms. • Every Pre and Post Move support included an adequate description of what the Post Move Monitor should look for when doing PMM (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. For none of five CLDPs (0%) reviewed was there sufficient descriptions or adequately defined criteria. There was some progress noted in the description of the evidence that was required to demonstrate a support was adequately in place. The IDTs more often identified evidence beyond written documentation than in the past,	Noncompliance

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		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 she should observe and what staff should be able to explain about the supports to be provided. The importance of this will only be magnified by the anticipated volume of transitions pending. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of Pre and Post Move supports has a rationale as to why it was not included. Examples of deficiencies as to the above criteria in the CLDPs reviewed included: • For Individual #359, given months of progressive weight loss as described in Provision T1d above, the CLDP should have identified careful monitoring of the situation, but fell short of doing so: o This issue was not noted in the health risks to be in-serviced. o The IDT had increased the individual's caloric intake from 2000 to 2500 in the month before transition, but the CLDP indicated the dietitian was to provide the community provider with sample menus of a 2000 calorie menu. o The CLDP indicated the individual was to be weighed monthly. More frequent weights should have been in order. In addition, there were no parameters provided as to what actions needed to be taken regarding the weight findings. • Also for Individual #359, the individual was prescribed TED hose for circulatory risk. It is very important that the direct care staff are trained in the correct way to put them on and how to monitor for problems with impaired circulation and to report to the nurse. TEDs applied to the lower extremities can cause undue pressure on the feet, as well as back of the knees leading to serious impairment of circulation leading to pressures ulcers at the bend of the knees that are extremely difficult to heal. In addition, if they are too loose fitting they will not be effective in reducing swelling and improving circulation. The TED hose were not referenced in the pre or post move supports. • Individual #133 was to have his blood pressure taken and recorded each day, but the CLDP listing of supports did not provide the rationale for this activity or any parameters for action needing to be taken by the staff. In this instance, the blood pressure was to be taken to determine if a medication was to be given or held. The listing of pre and post move supports did not provide this information, nor was it present in the body of the CLDP. It was only to be found in an	

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		addendum to the annual psychiatric summary. As described further in Provision T2b, the provider staff for this individual were completely unaware of the reasoning for this support and had only taken it once since the individual's arrival seven days before. The medication had been given routinely. This was of particular concern because the individual appeared to be lethargic despite his reputation for being very active. As a further illustration of the deficiencies in many of the above criteria, the Monitoring Team completed a focused review of supports and services related to dental care and found these were consistently not adequately addressed in five completed CLDPs. Findings included: • For only one of five (20%) CLDPs, were there dental summaries or recommendations included in the Current Summaries/Assessments and Recommendations section of the CLDP. • For none of five (0%) CLDPs were there any supports to identify a community dentist who could meet an individual's specialized needs, even though several required IV sedation. • For none of five (0%) CLDPs, were there pre or post move supports identified that addressed needed dental care. For example: o Individual #476 needed prophylaxis every three months. The last documented prophylaxis was 3/19/13 and the discharge date was 5/29/13. To maintain this recommended schedule, the individual would have needed to be seen by a dentist within a few weeks of discharge. No support related to dental care was documented. It was also noted in the handwritten dental assessment that the individual had some dentures and partials, although the exact number was illegible, but this was not reflected in the CLDP. o Individual #763 was also on a three month recall, having the last annual exam on 2/11/13. The individual's discharge date was 3/28/13, but there was no support to ensure a three month follow-up which would have been due 5/11/13. o For Individual #385, who had severe periodontitis, there was no dental assessment included. o For those individuals who had an oral care support included, there was insufficient definition of the evidence the Post-Move Monitor would need to review. The typical evidence required was observation and/or staff interview, but there was no specificity as to what knowledge the staff should be able to demonstrate. <u>Pre-Move Site Visit Completed by Facility:</u>	

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		The Transition Coordinator or Post-Move Monitor completed the Pre-Move Site Visits reviewed. No such visits were conducted during the monitoring visit, so the Monitoring Team was not able to observe the process but rather relied upon documentation to assess compliance. The Monitoring Team reviewed the Pre-Move Site Review documentation completed for 12 individuals who had transitioned in the past six months. For the 12 individuals, a Pre-Move Site Review was conducted by the Facility for 12 (100%). • Twelve of 12 (100%) were completed on a timely basis. • The Pre-Move Site Reviews sometimes identified a completion date that was past the stated date of the visit itself. This should be clarified. • The Pre-Move Site Reviews did not routinely address the due dates or specific plan for post-move supports that would need to be in place prior to the 7-Day visit. • It was not generally possible to evaluate if each included a visit to each service provision site as this information was not specified. • Given the lack of knowledge exhibited by provider staff during the on-site PMM visit described in T2b below, the Monitoring Team also reviewed the Pre-Move Site Visits for any testing of staff knowledge of individual's needs for supports, services and protections prior to the move. For none of 12 (0%) was any such documentation found. Seven of 12 (58%) called for staff interviews related to at least some supports, but there was no documentation in any of the seven that suggested staff interviews were in fact completed . Only observations of the completed in-service materials and signature sheets were documented. The remaining four Pre-Move Site Visit Reviews only required review of signature sheets for completed in-service. As there tended to be no competency requirements for the provider staff in the in-services, reviewing a sheet that simply documented staff presence was not sufficient to confirm adequate knowledge to provide the supports and services required in the CLDP. <u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for 12 individuals who had transitioned to the community in the last six months and found that for 11 of 12 (92%) the LA Continuity of Care Pre-Move Site Review Instruments was completed within the required timeframe and included the required DADS QRS report as an attachment. In one instance, for Individual #229, the LA did not complete the visit. For two other individuals who moved on the same date (Individuals # 133 and #217) there were missing supports indicated by the LA, but the Pre-Move Site Review completed at the same time indicated those supports were present. There was no further documentation on how this conflict may have been resolved.	

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		Coordination of CLDP with provider staff: A review of completed CLDPs indicated provider staff were typically involved throughout the CLDP process. In five of five (100%), there was documentation of training of provider staff, visits by the individual to the provider sites and the individual's responses, and provider staff attendance at the CLDP. This did not appear to necessarily translate to provider staff having adequate knowledge to provide the supports as prescribed. As detailed in Provision T2a below, the observation of the PMM visit indicated staff were unaware of many essential details of the individual's supports and needs. Conclusion: This provision was found to be not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as areas of focus/priority for the next six months: • Assess and develop a corrective action plan related to the lack of knowledge of supports and services on the part of community provider direct care staff, including, but not limited to how the following may impact the level of knowledge and competency: the structure, format, content and overall adequacy of the assessment basis of the CLDP as a whole, the structure, format, content and competency testing of the in-service training provided, and the adequacy of the implementation of the Pre-Move Site Review as it pertains to provider staff knowledge.	
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.	The Facility had implemented two new practices related to enhancing the quality of transition planning for individuals who had been referred. These included: • Exhibit I: Pre-Placement Medical Chart QA Protocol, was added to the Most Integrated Setting Policy on 3/20/13. The purpose of this protocol was to ensure individuals moving to a community setting had been provided with all medical services and supports needed prior to said move and to identify any medical issues that needed to be resolved. This process consisted of a review of the medical chart by an external physician, who provided findings and recommendations to the Medical Director for review and follow-up. The Director of CFR, the QA Nurse and the Primary Care Provider (PCP) also receive the report. All issues identified were expected to be addressed by the PCP within seven days of receipt. The QA review was required to be completed before the CLDP was held. This practice addressed previous findings by the Monitoring Team of unidentified health care needs of individuals residing at the Facility and involved in transition. • Exhibit J: Pre-Placement Doctor to Doctor Contact Protocol, was added to the Most Integrated Setting Policy on 3/20/13. The purpose of this protocol was to ensure that verbal communication occurred between the DSSLC PCP and the identified Community PCP prior to an individual's move to facilitate a successful	Noncompliance

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		transition. The steps in the process included providing a medical packet to the Community PCP, and arranging for, completing and documenting in the Integrated Progress Note (IPN) a telephone contact between the two physicians to discuss the medical status of the individual. The documentation was to be verified by the Health Services Coordinator prior to the move and re-verified by the Post-Move Monitor at the 7-Day PMM Visit. • The Facility also reported it had created a Community Living Discharge Plan Audit that identified key risks, preferences, community integration needs, accessibility and support needs and equipment needs which would evaluate whether these were adequately addressed in the CLDP. It also addressed whether the CLDP assessments were completed on a timely basis and reviewed as required. There were no data provided as to the implementation of this audit at this time, as it was a new process to be implemented. <u>Conclusion:</u> This provision was found to be not in compliance. These processes were new and there was evidence that some were not yet producing the desired results, particularly in the case of the Pre-Placement Medical Chart QA Protocol, as further described in T1d and T2b. Nevertheless, the Facility is to be commended for developing these promising practices.	
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,	<u>Facility Annual Obstacles Report:</u> The Facility provided an updated Annual Report: Obstacles to Community Transition, Denton State Supported Living Center, Fiscal Year 2012 for review. The report was dated November 2012 and noted the Center had had a steadily declining population they attributed more to community transition than to the deaths of individuals living at DSSLC. The report noted minimal data regarding the obstacles to referral or transition other than the LARs' reluctance for community placement, which was indicated as 291. The Facility further identified center strategies and actions to overcome or reduce obstacles to referrals and transition to the community. Action Plans were devised to continue to promote education an awareness of community living options, occurring in multiple venues, to address reluctance among all parties; to continue to identify and collect data on obstacles to referrals with a particular emphasis on identifying those individual who prefer community but have an LAR who has disagreed with a referral being made; and to collect data regarding open referrals that exceed 180 days in achieving a community transition. In addition to this report, the Facility provided a document entitled Analysis of Obstacles, dated March 2013. This report is described in more detail in Provision T1b1.	Noncompliance

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	and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	DADS Annual Obstacles Report: DADS had also issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • Definitions: Section T.1.b.1 of the Settlement Agreement required that the Facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The State's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." This definition does not seem to adequately capture those issues, barriers or impediments that could prevent an individual from making a choice of a more integrated setting, including a lack of awareness on the part of the individual or LAR or LAR reluctance. These are frequently identified obstacles to individuals' movement to the most integrated setting, and the data in the report reflect that this is so. • Referrals: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared Facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had	

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		expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives; however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek	

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		assistance from other state agencies (e.g., DARS). Conclusion: This provision was found to be not in compliance.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The Facility did provide an accurate Community Placement Report for one year ending on 7/22/2013 that included the following information as further detailed in T1a: • Number and names of individuals placed in the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion and included the required categories.	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate**		

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	to Their Needs		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Policies and Procedures related to Post-Move Monitoring: The Facility reported it had begun using a revised PMM Checklist in May 2013. This Checklist was condensed from the most recent version and closely resembled an earlier document. Staffing: There was a single Post-Move Monitoring position. Given the volume of recent community transitions and current referrals, the Facility may want to re-evaluate whether this will be sufficient to support successful transitions. It was reported that Transition Specialists were participating in PMM visits, and in at least two instances had taken responsibility for completing the PMM process. QA Nursing staff had also had some involvement in PMM, which the Monitoring Team commends. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for 15 individuals who had moved to the community for both timeliness of the PMM visits and the use of the standardized tool for completing the assessment for the presence of CLDP-prescribed supports. Findings included: • Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner. For 15 individuals, 31 reviews should have been completed since the previous review. Of the 31 required visits, documentation and staff report indicated 31 (100%) were conducted and 31 (100%) were completed on time. The Monitoring Team reviewed 26 checklists for 11 of these individuals and attended the PMM visit for one. The visits that were due for the remaining four individuals were reported to have been completed during the previous week but the documentation was not yet available to review. According to the ATC, the Post-Move Monitor had seven working days to complete the PMM Checklist. • Locations visited: For the PMM visits conducted for which documentation was available and for which the day program had begun, each (100%) included visits to all sites at which the individual lived and worked/day activity (e.g., day program, employment, public school). • Use of Standard Assessment Tool: For the 26 PMM visits conducted for which documentation was available, 26 (100%) were documented in the proper format, in line with Appendix C of the Settlement Agreement. The Post-Move Monitor also gathered documentation of the completion of supports and maintained these materials in a file. Assessment of Presence of Supports Called for in CLDP: The PMM Checklists reviewed appeared to include a verification that each support was in	Noncompliance

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		place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor often took actions and maintained a record of emails and phone logs that documented follow-up and loop closure. However, the findings in T2b below indicated the PMM process was not as vigilant in this regard as necessary. Facility's Efforts to Ensure Supports are Implemented: Overall, there was improvement noted in this area since the previous monitoring visit. The Monitoring Team found no evidence in the documentation provided that the Facility failed to take assertive action on a continuing basis to ensure supports were implemented. The Facility had a formal process for tracking follow-up activities to PMM visits. This process called for the Post-Move Monitor to document the area of concern, the action to be taken, the person responsible and the date due. It also included fields for additional comments and recommendations to the IDT for follow-up, if any. Copies of all evidence were to be attached to the form. Both the Post-Move Monitor and the Admissions/Placement Coordinator signed off upon completion of the follow-up action. ISPA meetings following PMM visits: The Facility's Policy addressed special concerns that arise after the move, but did not require an IDT review after each PMM visit or the expectations for this review, including required timeframes. There was not a clear process in place to determine what might constitute a special concern that would require IDT review, however; it was reported this relied primarily upon the Post-Move Monitor, perhaps in consultation with other Department of CFR staff, to identify such a need. As described in Provision T1e, the Post-Move Monitor cannot be expected to have expertise in every area and must rely on the expertise of the team to identify emerging concerns that may not have been anticipated. The potential for negative outcomes related to this are further described in Provision T2a, as it related to the PMM for Individual #133. The Facility may want to re-consider whether it is valuable, for the health and safety of individuals who have transitioned, to provide IDT scrutiny in every case. In addition to providing this extra level of interdisciplinary scrutiny, it would facilitate the overall involvement of the IDTs in post-move monitoring and inform their development of well-defined and measurable support in the future. This was discussed in detail with the Department of CFR staff and the Assistant Director Of Programs. Barriers to thorough PMM Review and Improvements Needed in Monitoring: 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	

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		knowledge in addition to the paper review of a training roster. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team again commends the Facility for its efforts to implement the PMM process in a rigorous manner; however, continuing deficits remain as described in the next provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	<u>Observation of Post-Move Monitoring Visit:</u> The Monitoring Team accompanied the Post-Move Monitor on a 7-Day PMM visit for Individual #133. The Post-Move Monitor continued to demonstrate concern and a degree of diligence in this on-site review. It was clear she was knowledgeable of many, although not all, the individual's needs and preferences and had excellent rapport with the individual and with the provider staff. The Post-Move Monitor evaluated the presence and/or status of some pre-move supports and post-move supports through a combination of document review, direct observation, staff interview, and interview; however, there were overall deficiencies in the process. One significant deficiency resulted from a lack of adequate detail in the CLDP, as described in Provision T1e. This was reflected in the lack of awareness of on the part of both the Post-Move Monitor and the staff on duty of why the individual's blood pressure needed to be taken on a daily basis or how this information was to be evaluated to ensure medication safety. In addition, the CLDP indicated there was to be a scale to take the individual's weight, which the Post-Move Monitor asked to see. This scale was extremely small and not adequate for the individual, who could not balance safely on it. The CLDP called only for the scale to be observed. In other instances, the Post-Move Monitoring staff did not demonstrate adequate preparation or did not adequately test provider knowledge of the individual's supports. Overall, the Post-Move Monitor did little objective testing or probing of the staff's knowledge; instead, she offered considerable prompting. Examples included: • The Post-Move Monitor was not familiar with the type of seizures the individual experienced and was unable to accurately answer the provider staff questions in this area. This was in spite of the individual having been hospitalized for seizure activity just days before his transition took place. • The Transition Specialist participating in the PMM Visit was not familiar with the individual's behavior support needs and was not able to provide a staff member any information when he inquired about inappropriate toileting behavior. • The Post-Move Monitor asked to see the blood pressure monitor, but did not question the staff as to how it was used or for what purpose. The Monitoring Team was also concerned that the Post-Move Monitoring staff did not	Noncompliance

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		appear to be in any way alarmed by the individual's lethargy, which by all accounts was completely out of character. There was very little interaction with the individual, except from across the room, and he did not arise from the couch or appear to be very interested in the environment during the entire visit. There were at least two concerns in this regard. The Post-Move Monitor should always have direct interaction with the individual that would allow personal assessment of the individual's physical and social well-being, even if all seems well. In addition, the Post-Move Monitoring staff did not adequately assess this significant change in behavior as indicating any potential emerging problem. This would be the sort of information that the IDT should be alerted to and asked to consult, which again speaks to the wisdom of having the IDT review each PMM visit. The Post-Move Monitoring staff were not able to appropriately identify this as something that would have necessitated such a review, which could have resulted in important information being missed. Conclusion: 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. Given the volume of referrals and expected transitions, such deficiencies in the process are likely to become magnified if not resolved. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • Expand upon the initiative to ensure the CLDP provides an accurate and complete description of each individual's needs for services, protections and supports, including the specific evidence to be reviewed by the Post-Move Monitor, as described in T1e. • Additional training should be provided to all staff responsible for Post-Move Monitoring, focused on overall assessment skills. It was noted the Facility did plan to undertake some cross-training in this area to include the Director of CFR as well. • The Facility should consider identifying appropriate disciplines or clinicians, particularly familiar clinicians from the respective IDTs, to participate in PMM visits with the Post-Move Monitor when there are complex health and/or safety support needs. This will assist in ensuring supports are being adequately implemented and positive outcomes are being obtained; it would also provide technical assistance to the Post-Move Monitor in improving assessment skills.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered		

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	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 provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;	The Facility reported no alternate discharges during this past six months. This provision was not rated.	Not Rated

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	(f) individuals discharged pursuant to a court order vacating the commitment order.		

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Self-Assessment 07-08-2013 2. Denton State Supported Living Center Action Plans 06/21/2013 3. Denton State Supported Living Center Report for Monitors 4. Section U Presentation Book materials 5. Section U – HRO Activity Information 6. DADS Policy 019: Guardianship, effective 3/7/2012 7. DADS Policy 057: Self-Advocacy, effective 05/30/12 8. DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012 9. DSSLC Policy CMGMT 40: Advocate, effective 05/15/2012 10. DSSLC Policy CMGMT 41: Self-Advocacy, effective 05/30/2012 11. Rights Assessment, Form 6614, dated September 2011 12. Completed Rights Assessments for Individuals #42, #231, #288, #317, #490, #567, #667, #772, and #788 13. Integrated ISP Monitoring Tool 14. Guardianship Committee Minutes for the past six months 15. Self-Advocacy Minutes for the past six months 16. Denton SSLC Advocate Pool List 17. Guardianship documents for Individual #85 18. Advocacy assignments and related ISP Addenda (ISPAs) for Individuals #5, #34, #85 and #239 19. Assignment of Disability Rights Texas as advocate for Individuals #20, #23, #54, #125, #306, #368, #444, #452, #546, and #669 20. The most recent prioritized lists 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, dated April 8, 2013, July 5, 2013 and July 26, 2013 21. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 22. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 23. Guardian Specialists Monthly Updates on Individuals on Priority List & Preliminary Priority List for the last six months 24. Denton State Supported Living Center QA/QI Council Meeting: Data Analysis Report, including Section U, dated May 28, 2013 25. Skill Acquisition Plans (SAPs) for Individuals #250 and #546 **People Interviewed:** 1. Pam Garrett and Sezer Ruzek, Human Rights Officers (HROs) 2. Lori Powell, Director of Quality Assurance (QA) **Meeting Attended/Observations:** 1. Annual ISP meetings for Individuals #231 and #667 2. Guardianship Committee 3. Human Rights Committee (HRC)

	Facility Self-Assessment: 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. For Section U, in conducting its self-assessment, the Facility had recently begun using the Integrated ISP Monitoring Tool to evaluate how the teams were using the rights assessment and to measure the outcomes. The Facility had used certain relevant data from this instrument and presented some findings based on its specific, measurable indicators, such as tracking the completion percentage of QIDP and IDT training. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. There were a number of valuable Action Steps reported as having been completed, including implementing formal training in choice making for selected individuals in Self Advocacy Group to assess outcome and to evaluate impact on the capacity of individuals to make informed choices; meeting with QDDP Coordinator and QDDP educator to discuss and determine the way to include support for individuals to participate in decision-making consistent with the assessment of the input they can provide; and, developing a system to attend annual ISP meetings regularly to guide the teams about including individualized support relevant to identified needs to enhance individuals' participation in decision making consistent with the assessment of the input they can provide. There were no additional steps in progress, even though Facility QA/QI data indicated IDTs were not yet reaching even the self-identified standards in this area. 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 of the prior monitoring visits. The actions did not, therefore, provide a set of steps likely to lead to compliance with the requirements of this Section. Overall, the Facility rated itself as being in compliance with the following provisions of Section U: Provision U1 and U2. The Facility asserted that it had shown significant improvement over the years in Section U, referencing its implementation of all related policy and procedures, establishing an integrated a system and methodology about prioritizing needs of individuals, exploring ways of obtaining LARs or Advocates for individuals according to their needs, reviewing improvements periodically, and tracking numbers of individuals without LARs. While the Monitoring Team agreed there had been significant progress in the areas indicated, it could not yet find compliance in either of the provisions as further explained below. In addition, this assertion was also not consistent with the Facility's own QA/QI findings as to its lack of achievement of an acceptable rate of compliance with their own standards.
	Summary of Monitor's Assessment: This Section was not yet in compliance. A summary of noted progress included the Facility's continued development of its commendable capacity to provide advocates for individuals as an alternative to guardianship, with some ten individuals currently having an advocate assigned and a pool of advocates available for future needs. In one instance, the Probate Court had authorized a surrogate decision-maker rather than a legal guardian, which was a novel approach. The Monitoring Team also commends the Facility for its initiative in incorporating formal choice and decision-making training in its self-advocacy efforts.

	The Facility had begun to measure the impact this may have on the capacity of individuals to make informed choices in a small but meaningful way; for a few individuals, the curricula and materials were being used as a part of formal SAPs to enhance decision-making skills. The Facility had begun to implement a quality assurance process using the Integrated ISP Monitoring Tool for this Section, which should be valuable in efforts to reach substantial compliance. Other specific findings for each provision are as follows: **Provision U1:** 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 Monitoring Team remained concerned, however, that 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. While it may prove to be useful, the draft Rights Assessment in use at DSSLC is not a currently accepted standardized tool for assessing decisional capacity, nor do the IDTs appear to be proficient in using it effectively as an assessment device. The IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria. This remained the most significant barrier to achievement of substantial compliance for this Section. 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. . **Provision U2:** This provision was found to be not in compliance. It was reported eight guardians had been obtained during the past six months, and twelve since the last monitoring visit. Ten individuals had advocates assigned through the Advocacy program and another ten had an advocate designated by Disability Rights Texas. The Facility was implementing its Guardianship Committee in a thoughtful and organized manner, as called for in the DADS Policy. The Monitoring Team commends the Facility for articulating the specific roles and responsibilities of the Guardianship Committee in the overall decision-making processes related to Guardianship and Advocacy. As described above, the Facility needed to ensure it has an appropriate methodology in place to determine the actual need for guardianship or other supports before these decisions can be appropriately made. The Monitoring Team commends the Facility for its ongoing initiative toward incorporating formal choice and decision-making training in its self-advocacy efforts. This included the implementation of a formal choice-making curriculum obtained from another state developmental disabilities agency. The Facility had also begun to measure in a small but meaningful way the impact these supports may have on the capacity of individuals to make informed choices.

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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> No new DADS policies had been issued related to this provision. DADS Policy 019: Guardianship, effective 3/7/2012, addressed the development and maintenance of a prioritized guardianship list as required. The Monitoring Team has expressed concern in previous reports that the 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 processes, methodologies, or tools IDTs should use to assess objectively the need for an LAR, an advocate or other assistance an individual might need in decision-making. The Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed <u>Maintenance of Prioritized List:</u> The Facility maintained three lists of individuals who did not have current guardians, organized by area of residence. These lists were entitled 1) Preliminary Priority List, 2) Priority List and 3) Need for Successor Guardianships. Each included certain other information regarding rights restrictions for each individual. The Monitoring Team reviewed these lists for the prioritization process and for timeliness of updates: • <u>Prioritization Criteria</u>: The Facility reported there had been no change in the prioritization criteria it applied to this process. It continued to use prioritization criteria that were tied to its Integrated Risk Rating (IRR) data, as previously approved by DADS. 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 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. This strategy held promise for contributing objectivity to the prioritization process and should be reviewed by DADS for its potential statewide applicability. As the IDTs improve their abilities in evaluating risk in the IRR process, these data will likely become more reliable for use in the prioritization process. The list was complemented with a list of individuals' current guardianship	Noncompliance

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		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 April 8, 2013, which included prioritization decisions made up until the March 22, 2013 Guardianship Committee meeting. 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. Another 18 individuals without a current guardian were included in the Preliminary Priority List, dated Friday July 05, 2013, and were ranked on a priority scale from one (least in need) to twelve (most in need). The HROs also continued 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. A third list provided for review, entitled Need for a Successor Guardianship and dated Friday, July 26, 2013, included 17 individuals. • Timeliness of Updating Process: The SA requires the prioritized list to be updated semiannually. The Facility's lists were populated with the IRR data on an ongoing basis as Rights Assessments were completed. The lists were updated each Monday, rather than just semi-annually. In addition, as individuals on the Priority List obtained guardians, their positions were filled with individuals on the Preliminary Priority List with the highest identified need. As successor guardians were obtained, individuals were also removed from that list. Assessment of Functional Capacity to Render a Decision: The HROs continued to provide training and technical assistance to the QIDPs and the IDT members on the use of the first four pages of the Rights Assessment as the Facility's capacity assessment. This included attendance at one ISP for each QIDP and a competency review of the Rights Assessment completed at the respective meetings. The competency testing consisted of a review of the Rights Assessments completed by the QIDP and required that there was input described for at least two of the categories. Observations made by the Monitoring Team of two annual ISP planning meetings held during the site visit indicated there was some progress reflected in substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent, particularly for Individual #231. The completed Rights Assessments were not made available for review with the completed ISPs, but the Monitoring Team was able to evaluate how well this discussion was captured in the ISP document. A review of the completed ISPs indicated: • For Individual #231, the ISP included a complete and accurate description of the	

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		discussion observed during the annual planning meeting. The Monitoring Team was concerned, however, that it appeared the individual was being held to a higher standard for participating in informed consent than would be asked for the average person in the community. Individual #231 was described as not having the ability to provide informed consent in the area of medical services but could communicate concerns regarding medical treatments and matters. The individual was reported to understand medical information, but did not demonstrate an understanding of medical options in the important evaluations of risk versus risk to determine good choices in courses of action. Similar statements were made in the area of programming and psychiatric services. For example, it indicated the individual did not have the ability to provide informed consent in the area of psychiatric services, but has the ability to communicate concerns regarding treatment matters, largely focused on how he feels from taking the medications or the treatment, and can talk of symptoms in terms of how he feels and acts, but not have enough awareness to understand psychiatric problems "clinically." These examples provide a good example of why a standardized and objective methodology for determining the capacity to give informed consent is crucial to this process. There are likely many people living in the community who could be described in the same manner whose ability to provide consent would not be questioned. The ability to understand psychiatric problems "clinically" could not be considered the community standard for providing consent, for instance. • For Individual #667, it was observed during the annual planning meeting that there was some discussion of input the individual could provide in a few areas, but this was not well documented or incorporated in the ISP. The completed ISP documented indicated only that the individual was unable to make decisions related to more abstract or complicated issues, did have awareness for some issues in the area of medical services, programming, placement and financial concerns. The ISP went on to state the IDT reviewed all of the rights restrictions listed in the Individual Rights Assessment, and for each restriction, defined the restriction, identified the justification for the restriction, less restrictive interventions previously attempted, the level of risk with the restriction, the level of risk without the restriction, plan to reduce, eliminate or monitor the restriction and the next date the restriction will be reviewed. Further, it stated that when appropriate, training or a desensitization plan was developed for removing the restriction. None of the restrictions listed were related to the informed consent restrictions, however, nor did the Monitoring Team find evidence in the ISP that any strategies or training were focused on incorporating and/or enhancing the individual's ability to participate in decision-making in the areas related to informed consent.	

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		The extensive discussion and good documentation around informed consent for Individual #231 represented some progress in the IDT consideration of individuals' capacities. Overall, however, the Monitoring Team did not observe significant progress in terms of the outcomes of this process since the last visit. The Monitoring Team reviewed ISPs, including the Rights Assessments, for a sample of nine individuals, including one from each unit and from the two ISP annual planning meetings held during this monitoring visit described above. • For none of the nine reviewed (0%), did the IDT conclude the individual was able to give, or substantially participate in giving, informed consent in any of the six areas listed. • In nine of nine (100%) instances the IDT did make some attempt to provide a rationale for the determinations, but this was not based on any valid formal assessment process. • Although the focus of the Rights Assessment process was to be on the input individuals could provide even if they could not provide full informed consent in a given area, the Monitoring Team found this was not yet sufficiently implemented by the IDTs. There were instances in which the IDTs described the types of input a person could have, but these were rarely incorporated into corresponding actions or instructions within the ISP that would facilitate such input taking place. • For only two of the nine Rights Assessments (22%) did the IDT document any strategies to improve the individuals' skills or abilities to participate in decision-making as it related to the informed consent findings. The Monitoring Team also observed the review of the Rights Assessments for two individuals (Individual #152 and Individual #629) at a meeting of the Facility's HRC and found for none of the two (0%) did the HRC members address the informed consent restrictions in a substantive manner. The process observed consisted of a review of the information provided and little to no discussion prior to approval. There was no discussion as to how any input indicated had been integrated into the ISP. The HRC should address the informed consent restrictions in the same manner as other restrictions, including requiring rationale for any restrictions and the plans to reduce the need for them. <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, but the determination of need was not predicated on any formal or standardized process or tool. To move in the direction of substantial compliance, the Monitoring Team recommends	

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		that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility will need to prescribe an assessment process and/or tool rooted in objective evidence-based principles of decisional capacity, and further, ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	<u>Policies And Procedures Related To Obtaining Lars For Individuals In Need:</u> DADS Policy 019: Guardianship, effective 3/7/2012, provided guidance and protocol as to obtaining LARs for individuals who may need one. The Facility reported there had been no changes to the statewide policy. An attachment had been added to the local policy, DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012, entitled *How The Guardianship Committee Works: Responsibilities And Step By Step Guide For DSSLC Guardianship Committee*. This described in some detail how the Guardianship Committee, discussed in more detail below, was expected to function and clarified some roles and responsibilities, such as: • Guardianship Committee members were to review the facility priority list and progress notes for each individual on the priority list monthly to address any changes as needed. • The Committee was to review the status of process towards guardianship for each individual on the priority list and determine action steps, including whether to initiate family contact or court referral depending on the needs of the individual. • The Committee was to reviews IDT requests for a guardian or advocate for the individuals, based on integrated risk rating tool and the level of needs and then determine if an individual qualified to be added to facility Priority List. • The Committee, as a part of its review, was to evaluate the justification provided and, if necessary, invite the IDT to provide supporting documents if the integrated risk rating is not sufficient. The Committee was to further review hospitalizations, health issues, psychiatric issues, restrictive measures through input from different disciplines to determine who has the most need to be included to the Priority List. • A quorum was set for meeting and for decision-making. The Monitoring Team commends the Facility for articulating the specific roles and responsibilities of the Guardianship Committee in the overall decision-making processes related to Guardianship and Advocacy. <u>Facility Efforts to Obtain LARs:</u> The Facility had a Guardianship Committee, as required by the DADS and local policies, which met regularly on a monthly basis and undertook to review and evaluate referrals for guardians and other decision-making supports, to make	Noncompliance

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		recommendations for action and track progress. The Facility reported in response to the pre-visit document request that eight LARs had been obtained for individuals living at DSSLC during past six months. Of these, five individuals were newly adjudicated incompetent and three obtained successor guardians. Each had been reviewed through the Facility's Guardianship Committee consistent with policy. Since the document request was completed, another four individuals had obtained LARs and five guardianships were in process. The HROs reported they were carefully following up on expiring guardianships to assure continuity as well as providing education to current LARs and families about planning for successor guardians. Membership of the Guardianship Committee was consistent with both statewide and local policy requirements, although the Facility found that maintaining membership in all categories was sometimes challenging. Training and informational presentations were provided to the Committee on an ongoing basis at most meetings, as described in the previous monitoring report. The Monitoring Team was able to attend the Committee meeting held during this compliance visit. There was good attendance and participation. The HROs reported on their activities for individuals on the Preliminary Priority List and referrals for guardians or advocates received from IDTs, and the membership provided thoughtful input and guidance as needed. 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. Other organized efforts toward obtaining LARs as well as other appropriate decision-making supports for individuals included: • Advocacy Program: The Facility continued to implement its Advocacy Program, consistent with the policy described above. At the time of the monitoring visit, there were ten advocates from this program assigned to individuals living at DSSLC. There was also a pool of seven additional staff who had been trained and approved to serve as advocates who were available to be matched with individuals needing such support in the future. The HROs noted that the program still targeted existing staff to take advantage of their having already been through a background check. 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. In addition, Disability Rights Texas was serving as advocate for ten individuals living at DSSLC. In a novel approach, the Facility HRO's worked with the Probate Court to authorize an alternative to guardianship. For Individual #85, the Court authorized an advocate to act as a surrogate decision-maker as the least	

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		restrictive alternative. The Facility was ordered to provide the Court with a written notice regarding the status of the effectiveness of the implementation of this alternative after at least 45 days and no later than 60 days from the signing of the order. While the Monitoring Team commends the initiative of the Facility in examining less restrictive alternative supports for decision-making, it was not clear what the authorities and responsibilities of the surrogate decision-maker were to be or how the effectiveness was to be measured. This should be clarified. • Self-Advocacy Program: The HROs continued to provide support for the Self-Advocacy Committee. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit. There continued to be considerable emphasis placed on informed choice and consent over this time period. This included the implementation of a formal choice-making curriculum obtained from another state developmental disabilities agency. Various sessions had included: o Learning, Decision Making, Getting, Involved In Decision Making. And Our Right Of Decision Making o Talking About Decision Making And Participating In Decision Making Process o Talking About Decision Making/Choice Making o Decision Making/Choice Making, Community Living Options o Making Informed Choices The Monitoring Team commends the Facility for its initiative in incorporating formal choice and decision-making training in its self-advocacy efforts. The Facility had also begun to measure in a small but meaningful way the impact this may have on the capacity of individuals to make informed choices. The HROs provided examples of SAPs designed in collaboration with the Facility Active Treatment Committee for two individuals using their own Decision-Making Books when making decisions. • 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, the HROs also received the following trainings: o Completed a three hour training on Person-Centered Thinking o Completed HRC Committee Training o Completed Ombudsman Rights Training Quality Assurance Processes: The Facility had recently begun to implement a quality assurance process for this Section, which the Monitoring Team commends. The Monitoring Team reviewed the Denton State Supported Living Center QA/QI Council	

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		Meeting: Data Analysis Report, including Section U, dated May 28, 2013, and interviewed the HROs and the QA Director. The process utilized the Integrated ISP Monitoring Tool, which included a section of 16 questions related to the completion of the Rights Assessment by the IDT. Four of these related specifically to informed consent: • Did the IDT discuss the areas which the individual can provide consent? • Did the IDT discuss the areas which the individual cannot provide informed consent? • Did the IDT discuss the areas which the individual can provide input to be part of the decision-making process? • Did the IDT determine the above based on the individual's capacity assessments? Data from November 2012-April 2013 indicated the Facility was not yet meeting its own standards in any of these areas. The report also noted that not having a system-wide method for determining decisional capacity remained as a systemic challenge that DADS was continuing to address. <u>Conclusion:</u> This Provision was found to be not yet in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility need to prescribe an assessment process and/or tool rooted in objective evidence-based principles of decisional capacity and, further ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully. The Guardianship Committee should be provided with training regarding the assessment process as well to facilitate their appropriate review of referrals made as a result.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-Assessment 7/8/13 2. DSSLC Action Plans 6/21/13 3. Presentation Book for Section V 4. Provision Action Information 5. DADS Policy 020.1 Recordkeeping Practices 3/05/10 6. DADS Policy: 009.2 Medical Care 5/15/2013 7. DSSLC Policy CM-25 Recordkeeping Practices 2/6/13 8. DSSLC Policy CMGMT 03 Integration of Clinical Services 5/31/13 9. DSSLC Policy CMGMT -14 At Risk Individuals 1/15/13 10. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 6/17/13) 11. DSSLC Policy Medical-01 Medical Care Exhibit G—Process for Consultations 7/1/13 12. DSSLC Dental Services, Dental Care—Suction Toothbrushing Protocol D8-04 4/23/13 13. Individual Notebook & Guidelines—Extension of Active Record 3/17/11 14. Active Record Order & Guidelines 4/5/13 15. Master Record Purging Schedule 8/9/12 16. Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 (Section V Monitoring Tool) 10/9/12 17. Active Record Order & Maintenance Guidelines (AROG) Audit tool 18. Individual Notebook & Guidelines—Extension of the Active Record audit form 19. Record Audits, including emails regarding corrective actions for 15 audits conducted April through June 2013, for Individuals #132, #152, #167, #228, #253, #272, #370, #386, #650, #659, #679, #690, #696, #785, and #799. Audit documents reviewed included the Settlement Agreement Cross Referenced with ICF-MR Standards Section V form (the monitoring tool), Individual Notebook & Guidelines (audit tool for Individual Notebook), Active Record Audit tool, and emails listing corrective actions needed 20. Active Record, Individual Notebook, and list of corrections needed based on records audit for Individual #690 21. Policies and Procedures Manual Index 22. Policy Tracking Log 23. Training materials—Observing and Reporting in MH and ID Facilities 24. Training materials—Recordkeeping 25. Interview Tool Data Tracking Sheet 26. QA/QI Council Meeting: Data Analysis Report for 5/28/13 27. Record Audit tracking data for May 2013 28. Share Drive information on assessments for Individual # **People Interviewed:** 1. Joint Interview of Melissia Steele, Unified Records Coordinator (URC), Betsy Knight, Records

	Administrator, and Lori Powell, Director of Quality Assurance (QA), regarding recordkeeping 2. Lori Powell, Director of Quality Assurance, regarding policy development and implementation 3. Joint interview of Leslie Clark, QIDP Coordinator, Julie Kuester, QIDP Education, and QIDPs David Bailey and Tony King **Meeting Attended/Observations:** 1. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 7/24/13 2. ISP Annual Planning Meeting for Individual #626 3. ISP Preparation Meeting for Individual #519
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V. 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. For Section V, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 ▪ Active Record Order & Maintenance Guidelines (AROG) Audit tool ▪ Individual Notebook & Guidelines—Extension of the Active Record audit form ▪ Interview questions for V4 ▪ ISP Monitoring Tool o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement for Provisions V1, V3, and V4. o The monitoring tools included adequate methodologies, such as audits of records and observation of meetings with documentation of specified actions. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. This sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: ▪ Melissia Steele, Unified Records Coordinator ▪ Sarah O'Brian, Program Auditor o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were programmatically competent in the relevant area(s). o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the record audit tools but was not reported for the ISP Audit Tool.

	▪ Used other relevant data sources and/or key indicators/outcome measures. Data were provided on audit corrective action completions. All other data were derived from the audit tools. The Facility provided the corrections data in a meaningful/useful way based on a specific, measurable indicator. These data were collected by the Unified Records Coordinator, who is part of the QA Department. ▪ The Facility rated itself as being in compliance with the following provisions of Section V: Provision V3. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Complete, In process, or Not started. ▪ The Facility data identified areas of need/improvement. As noted below, these have been addressed but may need additional actions to accomplish the improvements needed. ▪ The actions did provide a set of steps likely to lead toward compliance with the requirements of this Section but not likely, by themselves, to achieve compliance. For example, for Provision V1, the Facility provided a sequential set of steps for training new staff, including a pilot program for periodic review of documentation when staff began work following orientation. This was an excellent plan. However, training alone would not accomplish continuing compliance; other steps would be necessary to ensure adequate monitoring of quality of documentation, perhaps by management and supervisory staff. For Provision V2, the completed action steps included developing a system to track training on new policies but no steps to implement the system. The Facility should review the findings of this report to identify additional actions it might consider.
	Summary of Monitor's Assessment: 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. The auditing process has come into substantial compliance. 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. Records were accessible and secure from view. Both reviews by the Monitoring Team and audits by the Facility identified a few requirements of Appendix D that were frequently problematic. The audit system included a careful process for following through and ensuring corrective actions were completed. The Share Drive provided a means to make records readily available. As with the paper records, although there had been improvement in timeliness, some assessments were not posted timely to the Share Drive.

	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. The Facility should consider determining reliability for a sample of the audits on presence of documents. 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 except one. The Facility reported having taken systemic corrective actions for several issues including gaps on pages and legibility; the effectiveness of these actions had been mixed, and the Facility was continuing to address these. 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. Meeting observations, as documented by both the Facility and the Monitoring Team, indicated that information from records was not consistently used in making decisions. 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 had developed a new database to track training on policies and was in process of completing implementation. The Facility should consider also developing processes to ensure policies continue to be implemented correctly.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	<u>Policies Governing Recordkeeping</u> The Facility had a policy to maintain a unified record; this policy was consistent with statewide DADS policy. DSSLC Policy CMGMT-25 Recordkeeping Practices operationalized DADS Policy 020.1 Recordkeeping Practices. The Facility policy governed maintenance of a Unified Record with the required components and consistent with requirements of Appendix D. The Facility policy had been revised since the last compliance visit. The revisions was to scan hospital information into the O (Shared) Drive. <u>The Facility Maintains a Unified Record for Each Individual</u> To review this, the Monitoring Team requested records for many individuals as part of the reviews for several Sections of this report. The Monitoring Team also audited the Active Record, Individual Notebook, and Master Record for two individuals. In addition,	Noncompliance

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		the Monitoring Team reviewed the Facility record audits from April, May, and June 2013 to determine whether they reported the presence of all three required components. The Facility maintained a Unified Record for each individual. The unified record at DSSLC consisted of an Active Record, Individual Notebook (called the All About Me book), and Master 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. 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 (up to seven in the Infirmary), 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. 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. According to the Facility, the process for purging records and storing purged documents in and Overflow file had changed. In the current process, records clerks put overflow/purged documents into boxes and ship them to the records storeroom. This can result in purged documents being out of the active record but not yet in an overflow record for several weeks. Staff needing records can contact the Records Department and request that documents be retrieved. The Facility does not have a way to know if all purged documents are put into the boxes, but records audits (see Provision V3) identify whether records have been purged per the Facility's guidelines. To ensure purged documents are accounted for and remain available, the Facility should consider developing a process at least to identify what documents have been purged and are in the boxes. Based on audits conducted by the Facility, 15 of 15 (100%) audited records included an Active Record, Individual Notebook, and Master Record. In addition, the Monitoring Team audited records for Individuals #475 and #694; Monitoring Team audits found two of two (100%) audited records included an Active Record, Individual Notebook, and Master Record. For two of two individuals (100%), the Master Record was readily available. Each Master Record included a checkout form for checking out the record and a form to	

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		document copies made of documents and provided to staff or others. Staffing and Responsibility for Filing in the Record The Facility had staff assigned to oversee the Unified Record. The Facility had one Unified Records Coordinator (URC) and a Client Records department with a director and two clerks. In addition, twelve records clerks filed documents for the Units. The URC and Client Records department staff were part of the Quality Assurance Department. The Records Clerks were part of the Client Services Department. Training of Staff on Documentation The Facility provided training materials for an orientation course titled Observing and Reporting in MH and ID Facilities. Part of this training included training on documentation, including Appendix D guidelines. The training included practice. The URC and a Records Clerk provide training during orientation on Recordkeeping. This training covers the requirements of Appendix D, among other topics. Both classes included a competency test. The URC reported that any individual who missed more than two items on the Recordkeeping test must retake the class. Accessibility and Security of Records To assess whether records were accessible to staff for use in providing supports and in making decisions, and were secure, the Monitoring Team observed the records at apartments 504C, 508A, 513C, and 520A, and reviewed the data provided for the data analysis report of 5/28/13. For four of four individuals checked (100%), the Individual Notebook was readily accessible. For four of four individuals checked (100%), the Active Record was readily accessible. The Facility had a process for checking out Active Records, but errors in use of the process made this process less than fully effective. Each apartment had a checkout book in the chart rack where Active Records were kept. The Monitoring Team checked the checkout book for eight individuals. The checkout book was present in four of four apartments (100%). For five of eight records checked (63%), the checkout form was accurate; for each of these, all records were present, and there were no checkouts without returns documented. For Individuals #373, #476, #507, and #573, at least one chart had been checked out but not documented as checked back in; for all these individuals, the charts were all present. In addition, there were three instances in which a complete record being gathered for the Monitoring Team could not be found readily;	

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		these had evidently been taken to other departments, but the checkout form had not been completed. After a delay, all were found and provided. The data analysis report provided a bar graph for Individual Notebook Security for February, March, and April 2013 by unit. For April, all but two units were reported as 100% (most units had two numbers—such as TH1 and TH2, and the total number of units on the graph was 13). One unit, HP1, had continuing low rating and should be addressed. <u>Accuracy and Completeness of Records</u> To determine whether records were completed in compliance with Facility policy and Appendix D of the Settlement Agreement, the Monitoring Team reviewed the last quarterly data report for Section V and conducted audits of the complete unified record for Individual #694 (who had been admitted since the last compliance visit) and Individual #475 (selected by computer randomization from the five records randomly selected by the Facility to be audited by the Facility in August 2013). The Monitoring Team checked for the presence of each item on the Active Record Order & Maintenance Guidelines (AROG) Audit tool and the Individual Notebook. To do this, the Monitoring Team used the same audit forms used by the Facility; these forms listed each document and "Maintenance Guidelines" (the purging schedule and, for some documents, instructions). For the Active Record Audit tool, there was a box for each document to indicate present, missing, or not applicable. In addition, the Audit tool had a column to "Check if Meets App. D Criteria" and circle if it did not. For the Individual Notebook, there was just one unlabeled column that was to record whether documents were present or missing. 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/Skill Acquisition Plan would be in the appropriate section of the record. For Individual #694, 66 documents were present in the Active Record, 14 required documents were not present, and 158 documents were not applicable. Therefore, 66 of 80 documents (83%) that should have been in the Active Record were found in it. In the Individual Notebook, 11 of 14 required documents (79%) were present, and 12 documents were not applicable. For Individual #475, 79 documents were present in the Active Record, 13 required	

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		documents were not present, and 147 documents were not applicable. Therefore, 79 of 92 documents that should have been in the Active Record (86%) were found in it. In the Individual Notebook, 12 of 12 required documents (100%) were present, and 14 documents were not applicable. 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. Although Appendix D requirements were usually met, there were instances in which this was not the case. To assess whether Appendix D requirements were met, the Monitoring Team took two actions. For documents found in the Active Record, the percentage that met Appendix D requirements was calculated. Also, the Monitoring Team completed the Section V Monitoring Tool, which listed Appendix D requirements and was the primary tool used by the Facility to report results of records audits (see Provision V3). • For Individual #694, 61 of 66 documents in the Active Record (92%) met Appendix D requirements. The Monitoring Team's audit using the Section V Monitoring Tool found 16 of 25 checked Appendix D items (64%) to be compliant. • For Individual #475, 67 of 79 documents in the Active Record (85%) met Appendix D requirements. The Monitoring Team's audit using the Section V Monitoring Tool found 24 of 27 checked Appendix D items (89%) to be compliant. • On the Section V Monitoring Tool, "Complete" was marked noncompliant on both audits, as was "Entries are in reverse chronological order." To be complete according to the Facility's definition, "All of the documents and documentation in the record is complete, meaning that there are no missing assessments, reports, progress notes, etc. or missing pages from any of these documents." The definition permits one missing document or page to result in a finding that the record is not complete. The Facility provided trends data for compliance with the Section V monitoring tool items. The monitoring tool data covered 15 instruments submitted by the URC and 15 by records clerks. A graph of quarterly compliance for four quarters through February-April 2013 showed compliance averages for all aspects of this Section (including V2 related to policy rather than to Appendix D requirements) greater than 85% for the first three quarters and a slight decrease to 84.5% for the current quarter. A graph of averages across the year by section of the monitoring tool showed compliance of 99% for presence of all components of the Unified Record, 70% for compliance with Appendix D requirements for documentation practices, 85% for security of records, and 73% for	

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		accurate recordkeeping practices. The last quarterly data report showed average compliance for the last four quarters ranging from 84.5% to 89.7%. The Monitoring Team found one record to be within this range and one record lower that this range. The record with the lower compliance was for an individual who had been admitted to the Facility within the past six months; the Facility may wish to do further review of records of newly admitted individuals to determine whether this occurs frequently, or whether the sampled record was unusual; if the Facility finds the same issue for other records of newly admitted individuals, it may consider how to improve compliance for new records. The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included: • DSSLC uses "Red Notebooks for DSPs" to provide instructions on health care plans rather than putting them in the Individual Notebooks. These Red Notebooks are readily accessible. DSPs knew where they were located and were aware of the instructions. The notebooks contained individuals' Integrated Health Care Plans that had been developed to date. These were not considered part of the Unified Record and were not included in the audits discussed on Provision V3; nevertheless, the Facility had been using this process for an extended time, and it appeared to provide staff with the information they need. • 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. Also, late entries were not consistently documented correctly. Furthermore, IPNs often had blank lines between entries, as well as blanks left on the remainder of the sheets. • As reported in Provision O3, per review of the Medication Administration Records (MARS), Dining Plans, and PNMPs in the "Me" books, there was a pervasive issue with consistency among documents as the vast majority were contained different revision dates and therefore contained different information. For example: Individual #4's plan in his MAR was 2/15/13 while his plan in his "Me" books was revised and dated 7/19/13. Another example was Individual #247's dining plan in the MAR was dated 8/8/11 while his dining plan in the dining room was revised and dated 6/17/13. Failure to have consistent plans results in an increased likelihood of inconsistent care and therefore exposes the individual to unnecessary risk. <u>Use of Share Drive</u> The Share Drive provides a means to make information more readily accessible. Many documents, including assessments, are posted on the Share Drive and can be accessed by	

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		clinicians, QDDPs, and others who have a need for the information. 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. As part of an interview with two QIDPs, the Monitoring Team asked them to select an individual who had an ISP annual planning meeting scheduled within the next 10 working days. For that individual, the QIDP easily accessed and reviewed the assessments due and posted to the Share Drive. This information is reported in Provision V4. One change that had been made since the last compliance visit was that hospital information will be scanned and put into the Share drive, which will make the information more accessible to IDT members. In addition, the URC showed the Monitoring Team a file structure being implemented to make location of documents consistent, so they can be found easily. This structure should be in place for all records by the time of the next compliance visit. The Share Drive 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> DSSLC Policy ADM 1-01 governed policy development. 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. According to the Director of Quality Assurance, who is responsible for oversight of the policy development process, two changes had occurred since the last compliance visit. First, a Policy Committee had been put into place in January 2013. This committee includes members from various departments. When new policies are drafted, they are submitted to the Director of QA, who forwards them to the policy committee members for review. The committee discusses any recommendations for changes in policy; the policy writer is invited to the committee meeting. The committee discusses with the policy writer who needs to be trained, how long it will take to train everyone prior to implementing policy, and what kind of training needs to be done. The policy with revisions is re-submitted to the Director of QA, who finalizes the draft and submits it to the Facility Director for review and approval. The second change was a decision by DADS State Office regarding how the Facility operationalizes statewide policies. Instead of drafting a new policy, the Facility is now expected to include the state policy in the policy manual and to draft an exhibit that	Noncompliance

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		operationalizes the policy to the Facility. This was evident in exhibits provided to the Monitoring Team in response to a request for policies implemented since the last compliance visit. <u>Training on Policies</u> The Director of Quality Assurance stated the process for identifying need for training had changed. As stated above, the policy writer discusses training with the Policy Committee; they jointly determine, as part of the policy approval process, who needs training. The policy writer is responsible for collecting training sign-in sheets when these are required, and for submitting those to the QA department, which has a policy database to track training. This database was new, and not all names were populated yet. Therefore, the Monitoring Team could not use this to assess whether training had occurred or to match the information on the database against a sample of sign-in sheets. When this database if fully populated, the Facility will be able to run a delinquency report. This database was merged with the employee database, so it can be kept up to date with the employee listing by department, unit, and job class. The database should provide an effective means of tracking training and ensuring staff who need training on policies receive it. For some policies, the Policy Committee may determine that competency-based training is required. The Facility might wish to consider how to ensure that staff were trained to competence on those policies. <u>Development and Revision of Policies to Implement Part II of the Settlement Agreement</u> There is evidence that many protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed; however, some essential protocols and procedures remain to be developed and implemented. <u>New and Revised Policies:</u> The Facility and State had developed or revised policies necessary to implement Part II of the Settlement Agreement since the last compliance visit. New or revised DSSLC policies from Index (after October 2012) included: • Client Mgmt 01A Protection from Harm-Abuse, Neglect and Exploitation 2/1/13 • Client Mgmt 01 B Incident Management 2/1/13 • Client Mgmt 25 Record Keeping Practice 2/6/13 Other new or revised DSSLC policies and procedures from Policy Tracking Log, document request information, or information provided during the compliance visit included:	

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		• CMGMT 03 Integration of Clinical Services 5/31/13 • Medical-01 Medical Care Exhibit G—Process for Consultations 7/1/13 • CMGMT-14 Addendum H, At Risk System 2/1/13 • C&C-23, Medication Variance Committee Policy 4/24/13 • DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 6/17/13) • C&C-05, P&T Committee Policy 4/10/13 • Pharmacy Policy #00, Pharmacy Services & Medication Practices 4/12/13 • CMGMT-42, Fall from Bed or Entrapment Risk Assessment 4/1/13 • Pharmacy Policy 34.1 Process for Adverse Drug Reaction Reporting 4/10/13 • DSSLC Process for Evaluation for Psychiatric Services Due to Change in Behavioral Status (03/08/2013) • DSSLC Dental Services, Dental Care—Suction Toothbrushing Protocol D8-04 4/23/13 New or revised statewide DADS policies included: • DADS Policy 009.2 Medical Care 5/15/13 • DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 12/3/12 • DADS Policy 02.3 Incident Management 11/20/12 • DADS Policy and Procedures 007.3 Psychiatry Services 05/01/2013 • DADS State Supported Living Center, Nursing Services Policy: Policy Number: 010.3 6/7/13 • DADS State Supported Living Center Procedure: Medication Administration Guidelines, Date: June 2013 • DADS State Supported Living Center Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Date: April 2013 • DADS Guidelines for Major Medication Review, Date: 3/13/13 <u>Examples of Policy Changes</u> 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. Treatments and interventions shall be modified in response to clinical indicators." One revision was the addition to the purpose of modifying treatments and interventions in response to clinical indicators. This important revision is also relevant to requirements of Section H and several other sections of the Settlement Agreement. 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	

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		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. Content missing from the policy included requirements for continuing education for PNMT members, evaluation process for individuals who are enterally fed, collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia, and revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor. That being stated, many of components were observed in practice during the course of the compliance visit. <u>Areas in Which Efforts Are Needed</u> A local policy/process did not exist that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services. DSSLC had a localized Communication Services Policy (CMGMT-23), but this did not include all necessary elements. While these areas were included as part of a draft policy, the policy had not yet formalized and the procedures/guidelines defining the specifics of how the missing components would be implemented was still a work in process and per the Director of Speech were not ready for formal review by the Monitoring Team.	
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> 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 from another unit (usually the "sister unit") to audit the Active Record and Individual Notebook. The URC stated she also audits each of the five records to provide an Interrater reliability check; audits provided in response to the document request confirmed that both a records clerk and the URC audit each selected record. 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 statewide Settlement Agreement Cross Referenced with ICF-MR Standards form (Section V Monitoring Tool), the Active Record Order & Maintenance Guidelines (AROG) Audit tool, and the Individual Notebook & Guidelines—Extension of the Active Record audit form. The AROG audit tool had been revised to differentiate between the presence of documents and whether documents met Appendix D guidelines. For each document, the tool had a rating for both the presence and whether the document met Appendix D	Substantial Compliance

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		guidelines. Five randomly selected records were audited each month since the last compliance visit. Audits were done of all charts in the Active Record and of the Individual Notebook. The audit included questions about use of the records in making decisions. Specifically, the audit included review of Integrated Progress Notes (IPNs) for evidence of integrated planning; the definition required more than five disciplines to document IPNs as evidence this was occurring. In addition to audits of the records themselves, the Facility had implemented two processes to review whether the information from the records was being used in decision-making. As described in Provision V4, the Facility had continued to use an interview process to determine whether staff could identify ways in which the record was used. The URC selected one audited record per month for which three relevant IDT clinicians for the individual responded to an email with three questions about use of the record (on some occasions, she conducted telephone interviews using these questions). She then rated based on whether the clinicians stated the record was brought to and used at meetings, if they described an example of how the record was used at the meetings, and if they gave an example of how information from another discipline helped them make a decision. As reported in Provision V4, data from these interviews and email responses indicated staff could identify how the record was being used to make decisions. The second process involved direct observation of IDT meetings and completion of a checklist of items to be observed. Data from both these processes were consistent with the observations of the Monitoring Team. The interview process indicated staff could describe how the records are used, but the observation process found that records were not consistently used in decision-making during ISP planning meetings. <u>Interobserver Agreement/Interrater Reliability</u> As noted above, the URC and records clerk audit a record. For the three months of audits reviewed, six (40%) were dated the same day, two (13%) were dated one day apart, two (13%) were dated two days apart, two (13%) were dated three days apart, and one each (7%) were dated five and nine days apart. Because a record can be corrected and documents can be added or become outdated, it is best to review for reliability close together in time, preferably on the same day. Per interview with the URC, these audits are conducted independently, without discussion prior to comparing the results. Data on interrater reliability on the Section V Monitoring Tool was reported quarterly to the QA/Qi Council. Monthly averages from February 2012 through January 2013 were	

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		reported as ranging from 76% to 90%, with an overall agreement average of approximately 81% and a rising trend. For the five audits completed in June 2013, agreement ranged from 77% to 93% with an average for the month of 86%. The Monitoring Team selected one record to audit from the list of five randomly selected individuals provided by the Facility. Both the Monitoring Team and URC audited the record for Individual #475. These audits were conducted independently on the same day. Agreement on the Section V Monitoring Tool was 89%. The Facility did not report reliability data for the audit tools for the Active Record and Individual Notebook. Given that both the records clerk and URC audited these, the information is available to calculate reliability data for a sample of these (or even for all of them); this should be done. This would give information at a more detailed level than provided by data only on the Section V Monitoring Tool. For the Active Record reviewed by both the Monitoring Team and the URC, agreement on the Active Record Audit Tool between the Monitoring Team and the URC was 89% for presence of documents and 85% for whether documents met Appendix D requirements. Agreement on presence of documents in the Individual Notebook was 93%. Trend data on agreement on rating the Section V Monitoring Tool and data from the Monitoring Team and URC audit demonstrated acceptable agreement and indicated that definitions are adequate to permit reliable audits. The Facility should periodically review to determine whether there is any pattern of disagreement on specific items on the tool. <u>Audit Findings</u> Five audits were completed monthly in April 2013, May 2013, and June 2013. Review of 15 audits by the URC, for the three months reported, resulted in ratings of compliance for the monitoring tool with a range from a record showing 67% compliance to a record showing 97% compliance, with an average of 81%. This was slightly lower than the quarterly averages reported in the last quarterly report, which reported the overall average for the year from May 2012 through April 2013 as 87%. All monitoring tools reported that the three components of the Unified Record—the Active Record, Individual Notebook, and Master Record—existed. 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. Trend data were provided to the QA/QI Council in the Data Analysis Report for 5/28/13 on overall compliance percentages for the Section V Monitoring Tool, quarterly averages for the tool broken out by section of the tool, quarterly averages on the tool for the three provisions of this section that relate to recordkeeping, Interrater agreement by month, security of the Individual Notebook, record audit data (which reported frequency of	

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		errors for a number of categories of items that would apparently have been identified from the Active Record Audit Tool and Individual Notebook Audit Tool), and errors by discipline. These data were provided in graphs that showed current status and made trends evident. Audits reported certain issues had been found routinely. Some items were showing improvement over time, but others were not. For example: • There had been a decline in gaps in documents. These were usually blank spaces at the bottom of pages or in between entries, without a line through them. Although the audit tools showed few gaps in documentation, the Section V Monitoring Tool findings for June 2013 found two of five (40%) reflected gaps. • Legibility errors had been reduced, according to the record audit data. However, for the June 2013 audits, three of five (60%) were reported to have legibility problems, primarily involving signatures. Through review of records, the Monitoring Team noted that even where there were initial legends and signature sheets that required printed names, the printed names were sometimes not legible. • Documents were not provided in a timely manner for filing, so records were missing current documents. The Facility reported in the data analysis report that the URC will inform the Section Lead in addition to the immediate supervisors. • Documents were not being purged according to guidelines. These issues were consistent with what the Monitoring Team found both in the two independent audits and in use of the records done in the review for all sections of this report. <u>Corrective Actions</u> The Facility had a process to take corrective actions for specific deficiencies identified in audit of an individual record, to ensure corrective actions were completed, and to track deficiencies to determine trends that require systemic action. 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.	

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		For 15 of 15 audits reviewed (100%), documentation was provided that corrective actions were required for the deficiencies identified. 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. For 15 of 15 audits reviewed (100%), the Facility provided documentation that corrective actions had been completed within 10 days or follow-up notice had been given. Since the last compliance visit, the Facility had developed a record audit tracking tool. This consisted of a database that included corrections needed, date of audit, individual, unit, discipline, person responsible, category (type of deficiency, such as missing current document, need purging, and legibility), what will be evidence of correction, and dates the email requiring correction was sent, when corrections are due, and when they are completed. Based on this information, the tool also included graphs of corrections by home and unit and by category of error. The document provided to the Monitoring Team was not populated with all the data, and the URC reported that these data will be used to track effectiveness of systemic improvement or corrective actions (but that had not yet occurred in a formal way). This appears to provide the Facility with the ability to identify issues needing systemic improvement or to address issues specific to one home or unit. The Monitoring Team will be interested in learning, at the next compliance visit, how this tool is being used and what improvements result from review of the data. The URC reported that systemic improvement plans had been implemented on legibility of signatures, missing current assessments, gaps, and Interrater reliability. It appeared these actions had been effective in reducing gaps and improving Interrater reliability but had not yet been effective in improving legibility and getting current assessments to file. Although the plans had not been universally effective, it is positive to find that some actions had been taken, and that the Facility was developing a process to evaluate the effectiveness of those plans. The Monitoring Team reviewed the corrective action emails for the audits conducted in April and May 2013 and compared some specific corrections required to the information on audit tools. All items identified from the audit tools as needing correction that were checked by the Monitoring Team were noted on an email as needing corrective action.	

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		The Monitoring Team noted that most corrections were reported as completed timely, but many were still listed as not completed; for those, follow-up emails were provided. These findings indicate that follow-up documentation identified both corrected and uncorrected required actions. The Monitoring Team selected randomly by computer from audits done in August the record for Individual #690 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. Most cleared corrections had, indeed, been corrected and remained correct. One cleared item had not been corrected; the PBSP was reported as updated, but the PBSP in the record had not been updated. One correction had been made—skill acquisition plans (SAPs) needing purging had been purged—but, in the meantime, additional purging should have been done, and SAPs that had since become outdated remained in the record; all other purging had been done as required. For items that could not be changed in the record, the URC provided documentation that training or other action had been taken (such as training sign-in sheets). All in all, this review indicated that the process for tracking corrective actions was in place and was relatively accurate and effective. The URC should be cautious when informed that a document has been filed and should ensure that had occurred. Management and supervisory staff should ensure that documentation processes such as purging and legibility, once corrected, are reviewed periodically to ensure they remain corrected. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> As described earlier, the QA/QI Council reviewed trend data. The Data Analysis report for recordkeeping had expanded to additional types of data. As noted above, use of these data for identifying and addressing needs for improvement had begun, and the data were available for tracking effectiveness of actions. The system still needed to evolve and become more formalized, but it showed promise as a means to improve the quality and usefulness of the Unified Record.	
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. <u>Records are Accessible to Staff, Clinicians, and Others</u> As reported in Provision V1, Active Records and Individual Notebooks were, for the most part, readily available and accessible. Audits of 15 records found 15 (100%) to be accessible. In addition, two of two Active Records and Individual Notebooks audited by the Monitoring Team (100%) were accessible. The only difficulty was with the inaccuracy of the checkout process; an indication of the importance of that process was	Noncompliance

#	Provision	Assessment of Status	Compliance
		that three records could not be found when requested by the Monitoring Team as they had not been checked out but were not at the apartment (these were found after a delay). The Share Drive made assessments and other documents readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them; additional documents continue to be added. <u>Documents are Filed in the Record Timely and Accurately</u> The monitoring tool for record audits checked whether documents in the record were current. Responses to that item on the reviewed audits showed one of 15 records (7%) was rated as Current. 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 reported in Provisions H1 and S2, timeliness of annual assessments (that is posting of annual assessments 10 working days in advance of an annual ISP planning meeting to permit all clinicians to review assessments from other disciplines) had improved but remained variable. Data provided by the Facility indicated that timeliness by discipline ranged from 63% for Speech to 97% for Pharmacy. The Monitoring Team also viewed the assessments available on the shared drive for Individual #520, who had an annual ISP meeting scheduled within the next ten working days. For 15 of the assessments that were required per the ISP Preparation meeting, 12 (80%) were available. This was consistent with the compliance rate for the ISP annual meetings held during the monitoring visit. The Facility had taken effective actions to improve timeliness, but further improvement is needed. As reported in Provision H1, and as reported below regarding use of documents at meetings, the use of information from assessments was also variable. <u>Data are documented/recorded timely on data and tracking sheets</u> An audit of the record for Individual #694 showed gaps in data on SAPs. Other than that, there was no indication that data were not recording timely. <u>Staff surveyed/interviewed indicate how the unified record is used</u> To assess this item, the Facility reported in the Self-assessment that it conducted interviews using the Interview Tool for use of the Record. During interview, the URC reporting selecting one audited record per month for which three relevant IDT clinicians	

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		for the individual responded to an email with three questions about use of the record (on some occasions, she conducted telephone interviews using these questions). She then rated based on whether the clinicians stated the record was brought to and used at meetings, if they described an example of how the record was used at the meetings, and if they gave an example of how information from another discipline helped them make a decision. The Facility had developed a data tracking sheet for the interview tool. The Yes/No rating for each question for each interview was entered into a database. The overall percentage of Yes ratings for each month was displayed on a bar graph; the percentage had been 100% each of the last six months. Data in the self-assessment for six interviews reported six (100%) staff interviewed indicated routinely using the records to make decisions. The Monitoring Tool for the June 2013 audit for which interviews was done also rated this "Yes." The Monitoring Team also interviewed two QIDPs and asked these questions. Both QIDPs gave multiple examples of how the records are used during various IDT meetings (and other meetings, including the Physical and Nutritional Management Team as it addressed individual referrals) and identified specific information from the records that may be reviewed. They both indicated that records charts are used less during the annual ISP planning meeting because ISP preparation and use of the ISP agenda make much of the information available in advance, but are used more during ISPA and other smaller meetings. This interview indicated appropriate use of the records. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> The Facility used an extensive ISP monitoring checklist to assess a wide range of issues, one of which was use of the record at meetings. According to the self-assessment, data and information in the record were available and utilized in making decisions during 39.37% of meeting discussions (per interview, these appeared to reflect discussions at ISP annual planning meetings). The Monitoring Team observed the ISP annual planning meeting for Individual #626. The Active Record was present at the meeting. Although there was extensive discussion by several IDT members on most issues, there was no reference to information from the assessments. In fact, the speech pathologist conducted several brief trials to determine the individual's responses during the meeting (such as whether the individual could identify body parts) that should have been available from the assessment in the record; there was no way to know whether the skills being assessed during the meeting had or	

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		had not been covered in the assessment or in the Functional Skills Assessment. Furthermore, although there was extensive discussion during the Integrated Risk Review process, the lack of use of data hindered the process and possibly the accuracy of risk ratings. The Monitoring Team observed the ISP Prep meeting for Individual #519. The Active Record was present. The physician looked through the record to check information. The Nurse Case Manager brought additional information (perhaps gathered from the record) that included dates of hospitalization, seizure information, and medications. She also brought a copy of a neurology consult. This was a positive finding that likely indicated use of the record to prepare for the meeting. Data on the trend in frequency of seizures were discussed. However, although there was detailed discussion of the individual's communication dictionary, information from the record was not used when questions arose during discussion on communication supports. At the PNMT meeting observed by the Monitoring Team, the record was available and was referred to during discussion of past medical consults. Thus, use of information from records for decision-making at IDT meetings was variable. <u>Additional Information from the Monitoring Tool</u> In addition to the agreed-upon measures, the Facility used other information from the Section V Monitoring Tool in assessing compliance with this provision. One question on the monitoring tool was whether reviews of the integrated progress notes provided evidence the Facility routinely uses the records to make decisions. The process used by the Facility to do this review was to identify all disciplines that wrote in the IPNs during the prior six months and mark "Yes" if there were entries by more than five disciplines. The self-assessment reported that this occurred for 29 of 30 records audited over the period from December 2012 through May 2013. Of five records audited in June 2013, four (80%) were marked as "Yes" for this item. Of the two records audited by the Monitoring Team, zero (0%) had at IPN entries by more than five disciplines (one was of an individual admitted less than six months prior to the audit; for the other, the URC also rated this item as "No"). This was a valuable additional measure; while the results were not clear, it did provide some support for use of the record in making decisions. More important, it provides a process for the Facility to provide training and oversight to clinicians about how to use the record effectively to document information and to share it with other clinicians. <u>Additional Information from Records</u> It is essential that information needed for providing supports and services be consistent	

#	Provision	Assessment of Status	Compliance
		across documents. An example in which inconsistent information was provided was described in Provision O3. Per review of the Medication Administration Records (MARS), Dining Plans, and PNMPs in the "Me" books, there was a pervasive issue with consistency among documents as the vast majority were contained different revision dates and therefore contained different information. For example: Individual #4's plan in his MAR was 2/15/13 while his plan in his "Me" books was revised and dated 7/19/13. Another example was Individual #247's dining plan in the MAR was dated 8/8/11 while his dining plan in the dining room was revised and dated 6/17/13. Failure to have consistent plans results in an increased likelihood of inconsistent care and therefore exposes the individual to unnecessary risk. <u>Conclusion</u> Records were accessible, were brought to IDT meetings, and staff could describe how information from records was used. However, information from records was used inconsistently in meetings, assessments were not consistently posted in time to be reviewed by other clinicians before annual ISP planning meetings (although this was improved compared to prior compliance visits), and information in records was not always consistent across documents.	

List of Acronyms

Denton State Supported Living Center

July 22-26, 2013 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
ART	Administrative Review Team
AS	Action Step(s)
AT	Assistive Technology
BAIP	Behavior Assessment and Intervention Program
BAP	Behavioral Assessment Program
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
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
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
MRP	Medication Response Profile
MRSA	Methicillin-resistant Staphylococcus Aureus
MSP	Medical Support Plan
MTC	Mealtime Coordinator

MVC	Medication Variance Committee
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care/No Direct Contact
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NP	Nurse Practitioner
O2	Oxygen
O2Sat	Oxygen saturation
OCD	Obsessive Compulsive Disorder
OHCP	Oral Health Care Plan
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
PMTP	Psychiatric Medication Treatment Plan
PNA	Psychiatric Nursing Assistant
PNM	Physical and Nutritional Management
PNMC/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan

PNMT	Physical and Nutritional Management Team
PO	By mouth, oral intake
POC	Plan of Correction
POI	Plan of Improvement
PRC	Polypharmacy Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan; Psychiatric 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
RRC	Restraint Reduction Committee
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
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