# United States v. State of Texas

## Monitoring Team Report

## Denton State Supported Living Center
## January 13-17, 2014

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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, Katie Eberle, Wes Knox, Billy Hensley, Billy Bennett, Nora Brookins, and Sara O'Bryan. 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 469 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. As is noted for some Sections of this report, the Facility sometimes reviewed samples of documents or provided other information that would have been available through its routine quality assurance process. It is essential that the Facility have a quality assurance process that reports accurately on the status of important aspects of the Facility's services, staffing, and administrative functioning; for compliance with Settlement Agreement requirements to be sustained over time, the Facility must use this quality assurance process to identify when improvements or corrective actions are needed. Therefore, the self-assessment process should use information from the routine quality assurance activities and reports to the greatest extent possible.

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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. In Section J, 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.

**Specific Findings**

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal for the Monitor and DOJ's review, comment, and approval. This report reflects the results of a modified

review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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

Restraints

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 continued. This continued to be the case. 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.

- Positive Practices and Improvements Made
    - Restraint was only being used for crisis intervention. Through interviews with Facility staff it was clear 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.
    - During the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period.
    - No use of prone restraint was identified.
- Improvements Needed
    - The Facility continued to conduct auditing of restraint documentation for every instance of restraint use, using a standardized monitoring tool. This usually provided the necessary data to identify practice and documentation discrepancies requiring administrative follow-up. Nevertheless, 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.
    - Inconsistent restraint monitoring by nursing staff was noted and needs to be aggressively addressed.
    - Although progress had been made in complying with Settlement Agreement requirements associated with medical restraint, the consistent development of strategies and programs to minimize the need for medical restraint was still lacking.

Abuse, Neglect and Incident Management

As noted in the last report, the Facility had most of the administrative systems in place to achieve compliance with Section D but needed to pay more attention to detail, identifying problems and mistakes, and taking aggressive actions to correct them and prevent recurrence.

- Positive Practices and Improvements Made
    - The Facility continued three actions that had been implemented shortly before the last compliance visit: 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) reinforcing abuse and neglect reporting.
    - 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.
- Improvements Needed
    - Late reporting of allegations of abuse, neglect, and serious incidents still occurs too often.
    - The thoroughness and completeness of Facility review of facility investigations of UIRs was still not sufficient to ensure content of investigations was thorough and complete and that the report is accurate and complete.
    - Improvement is needed in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs).

<u>Quality Assurance</u>

The Facility had made substantial progress since the last review. QA activities noted in previous reports as "in the early stages of implementation" were becoming more routine.

- Positive Practices and Improvements Made
    - The Facility's QA process reviewed by the Monitoring Team demonstrated continued improvement in the organization and collection of data,review and analysis of data, substantive interaction between the QA Department, SA Coordinator and section leads, and presentation and review of data and analysis by the QA/QI Council.
    - There was a complete and adequate data list/inventory at the Facility and the list was current.
    - The Facility's data system had achieved a level of maturity such that multiple variables can be examined for most data points.
    - 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.
    - 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 QA/QI Council reviews each section of the SA at least once a quarter. 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 number of monitoring tools that have inter-rater reliability had increased; however the lack of inter-rater reliability is a primary barrier to compliance.
  - Processes for the development of corrective action plans needed improvement.
  - Many key indicators were insufficient to measure improvement or regression in the metric described in the key indicator.
  - 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. The Facility did not appear to have a systematic or reliable method to determine if a CAP was effective or not.
  - With regard to the corrective action planning process the Facility was struggling with developing data-related problem statements from which action steps could be articulated and improvement measured.

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

Progress continued, but improvements were still needed in all provisions. The Facility had recently embarked on an extensive training effort for QIDPs on the ISP process, facilitation and person-centered planning, and the QIDP Educator was in the process of becoming certified in Person-Centered Thinking. The Facility was to also to be commended for its continuing efforts toward developing a comprehensive quality assurance system for this Section.

- Positive Practices and Improvements Made
  - The Monitoring Team was able to observe continued progress in the participation of direct support professional (DSP) in the on-site meetings that contributed tremendous value to the interdisciplinary process.
  - The revised ISP format and process was still in use and considerable training and coaching continued to be provided to the QIDPs and IDTs. IDT participation, especially for DSPs, continued to show improvement.
  - Although there was not yet clear indication of effectiveness in identifying and remediating issues that would ensure ISPs are developed and implemented consistent with the provisions of this Section, 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.
  - Improvement is needed in the Facility's development of the ISP in accordance with the Americans with Disabilities Act (ADA) and Olmstead decision.

- 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 identified outcomes related to each preference and meet identified needs.
- Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies.
- Skill acquisition programs were not yet sufficiently constructed or assessed for progress.
- ISP strategies did not reflect encouragement of community participation in a meaningful or purposeful manner, although some progress was noted.

Integrated Clinical Services

The Facility had continued its progress toward providing clinical services in an integrated manner. There was evidence of integrated planning and services for individuals, as well as for systemic improvements. There remained examples in which integrated planning continued to need improvement.

- Positive Practices and Improvements Made
  - The Integrated Morning Report provided a good opportunity for integrated planning. Much of the meeting involved reporting, and there were a number of individuals or issues for which more in-depth discussion would have been useful. The number of individuals addressed makes it difficult to have extensive discussions. The Facility should address how to encourage active participation about both care of individuals and identification of systemic issues and improvements.
- Improvements Needed
  - Although the Facility had good policies and procedures, and a standard form, 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, improvements must be made in carrying out these processes.

Minimum Common Elements of Clinical Care

The Facility continued to take action to improve timeliness and use of clinical indicators. Nevertheless, although the Facility had approached substantial compliance with some provisions of this Section at the last compliance review, there had not been progress substantive enough to achieve substantial compliance with any provision. Although there were numerous venues to review clinical indicators, and there were efforts to address systemic issues, there remained areas in which clinical indicators were not used to identify needs for revisions to treatments and interventions and implement them.

- Positive Practices and Improvements Made
  - Both medical and psychiatric diagnoses were consistent with diagnostic coding standards.
  - Psychiatric diagnoses were consistent with the information contained in the psychiatric evaluations.
  - The use of clinical indicators to determine efficacy of treatments and interventions continued to expand.

- The Facility had continued to use or had established several systems to monitor the health status of individuals.

- Improvements Needed
  - Timeliness of assessments continued to be high overall but variable across departments, according to Facility data. However, review by the Monitoring Team found a larger number of assessments that were not completed according to policy.
  - Comprehensiveness of assessments, while improved for several disciplines, had not improved for others. DADS had implemented a new standardized assessment format, which has the potential to improve comprehensiveness of the assessment reports if the underlying assessment practices also improve.
  - Furthermore, use of assessment data to make decisions on treatments, supports, and services was variable.
  - Medical diagnoses, while they generally fit assessments and evaluations, in some cases required additional assessments to identify etiology or to confirm the diagnosis.
  - Timeliness of implementation continued to improve in many areas but remained variable.
  - In general, treatments and interventions were based on assessments and were clinically appropriate, but this was not consistently the case.
  - There remained cases in which treatments and interventions were not assessed for efficacy or in which decisions on treatment were not based on data on clinical indicators.
  - Monthly monitoring by the QIDP was not consistent and did not regularly include analysis of progress. An area for improvement remains ensuring monitoring is done regularly and documents progress or regression based on data and other information.

<u>At-Risk Individuals</u>

Although improvement had occurred in processes for identifying and addressing risks, further improvement is needed. In particular, many of the compliance scores reported in Provision I.2 and I.3 had improved from that reported in the last report by the Monitoring Team but need further improvement to reach an acceptable level.

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 Monitoring Team observed two ISP meetings held during the week of the review. Participation by relevant staff and use of clinical data in reviewing risk was improved from that noted at the last review.
- Interdisciplinary clinical coordination continued to improve from that noted in previous reports.

- Improvements Needed
  - While 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

The Facility made progress in a number of areas. Concerns that had been identified during the previous visit were addressed, and that made it possible for two provisions to come into substantial compliance. There was also a focus on integrated behavioral care that culminated in the introduction of the IBHA at the end of the review period. The two provisions that came into status of substantial compliance were: Provisions J10 and J14.

- Positive Practices and Improvements Made
  - For many medications, timely Human Rights Committee (HRC) reviews were not in place during the previous review period. During the current visit the Monitoring Team confirmed the continued presence of the identified processes, their documentation, and also their timely review by HRC.
  - Progress has been made in the presentation of psychiatric symptom data that will support monitoring of medication treatment for efficacy.
  - A new format for integrated behavioral health assessments was just introduced and it appears to be promising. Progress has been made toward integrated behavioral care, in part via the development of the IBHA format.
  - At psychiatric treatment reviews (PTRs), the presentation of materials was comprehensive and the psychiatrist typically followed up the presentation with questions to explore further the material presented. The Monitoring Team was encouraged to see that the presentation of psychiatric and behavioral data was in parallel but separate. That was important, since tracking on the psychiatric medication needed to reflect psychiatric symptoms and the tracking of behavioral symptoms needed to reflect learned behavior.
  - Comprehensive psychiatric evaluations (CPEs) were provided to all individuals for whom they were required.
  - The Facility has a good system in place to monitor side effects of psychotropic medications.
- Improvements Needed
  - Plans to reduce the need for pretreatment sedation were not in place. The Facility presented plans to expand interventions to reduce the need for pre-treatment sedation, but those too were not yet in place. Medical monitoring for safety during medical restraint also needed improvement.
  - Much work remains to review CPEs and ensure they meet standards.

Psychological services

Decline was noted across several provisions. This was most evident in relation to behavior assessments and intervention, the identification of behavioral aspects of mental illness, data collection and presentation, and the ability to effectively monitor treatment outcomes and exercise evidence-based practices in formulation of treatment decisions.

The Behavioral Health Services department at Denton State Supported Living Center employs several well-qualified professionals, contracts with other recognized experts for additional services, and maintains a professional relationship with the University of North Texas for behavior analytic training and services. As discussed later in this report, there were several examples of sophisticated assessments and interventions in the documents reviewed. It was therefore unexpected to find reduced performance during the current site visit.

- Positive Practices and Improvements Made
  - All Behavior Health Service staff either were BCBAs or were engaged in board certification prerequisites.
  - The Facility continued to employ a BCBA as director of the Behavior Health Services department.
  - The Facility continued to provide exemplary counseling services for those individuals identified as potentially benefiting from such services.
  - All reviewed behavior intervention plans included staff instructions that met readability expectations.
- Improvements Needed
  - A sizable portion of behavior assessments and intervention plans were developed by staff who were not BCBAs.
  - Slightly less than two thirds of data graphs were adequate for the development of treatment decisions.
  - According to the Facility tracking data, 29% of individuals living at the Facility had not been provided a psychological assessment report in the past year.
  - In comparison with the preceding site visit, behavioral assessments that reflected adequate functional assessment practices dropped by approximately 30%.
  - Approximately only one third of behavior assessments used evidence-based practices to differentiate between learned and biologically based behaviors where such practices were necessary.
  - Behavioral progress notes frequently described poor quality data, missing data collection forms, and poor cooperation by staff in the collection of target behavior and replacement behavior data.

Medical Care

The Monitoring Team has serious concerns over medical services at the Facility. Follow-up through to full resolution of medical issues; exploring underlying etiology of medical conditions; assertive and meaningful participation by medical providers within the context of the interdisciplinary team process; conducting efficacious assessment of performance standards of medical providers; ensuring a process that effectively determines the quality of medical services by collecting sound clinical data, analyzing the data, and developing and following up on effective action plans; developing, implementing and updating medical policies and procedures that delineate all areas of clinical, and clinical-administration activities; and ensuring a robust mortality review process, were some of the areas observed by the Monitoring Team to need improvement.

- Positive Practices and Improvements Made
  - All medical providers were currently licensed.

- The Monitoring Team noted continued and significant improvement with the diagnosis, monitoring and treatment of low bone density.

- Improvements Needed
  - Medical providers must improve participation in interdisciplinary team meetings.
  - In general, the Facility was not actively attempting to identify underlying causes of clinical issues, but was merely treating overt manifestations. It is essential that all clinical conditions be evaluated for the underlying etiology of the condition. The Facility was not ensuring that underlying causes of low bone mineral density was assessed, was not assessing efficacy of supports and services for the management of recurrent pneumonia, and was not routinely clinically assessing Individuals following seizure activity.
  - Medical providers must ensure that the IDT is well informed on all medical conditions, the etiology of medical conditions, how the condition impacts the life of the individuals, and all potential treatments, and associated risks and benefits of treatment and of not providing treatment for a medical conditions.
  - The external medical provider quality assurance audit process does not assess the medical providers clinical performance, and strongly recommends that the Facility review the audit tools, specific for this function. The Facility has developed a new process call the medical assessment of the assessment, which employs an external physician as the reviewer. The Monitoring Team believes that this new process may enhance the Facility's medical quality assurance process; however, this process has not been fully implemented, and there was no process to ensure tracking of action plans for deficient items

<u>Nursing Care</u>
Processes were in place for continuing improvement.

- Positive Practices and Improvements Made
  - Requirements were generally met for Hospital Liaison Nurses, Infection Control Program, and Emergency Response activities.
  - The Nursing Department had recently adopted, implemented, and trained the RN Case Managers on the state's standardized Nursing Assessment Form and Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment.
  - The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance.
  - 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 review of training records that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed. However, nursing audits did not yet provide information on implementation of

protocols; these were revised, and this information will be reviewed at the next compliance visit. Information from nursing audits will need to show a high level of accurate implementation or action taken to improve.
    - The Facility continued to maintain robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances, as reflected in the report.
- Improvements Needed
    - Requirements for documentation and assessment of acute change of status and skin integrity showed progress but continue to need improvements.
    - Nursing Administration was in the process of updating and refining Nursing Protocol Card Monitoring Tools and the Inter-rater Reliability Processes, which should result in improved outcome of audits.
    - The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. Recently the Facility developed, implemented, and trained the Interdisciplinary Teams (IDTs) on Risk Action Plan and Clinical Indicators/Data Considerations, which should assist the IDTs in ensuring that all relevant clinical data are considered in make risk rating decisions. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance, as reflected in the report.

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

The Facility continues to enhance efficacious pharmacy services. The Monitoring Team was impressed with the level of review, recommendations, and action plans developed by the pharmacy department, when addressing system and prescriber issues, within the context of polypharmacy and medication variance committee meetings. The Monitoring Team also noted significant improvement with the quarterly drug regimen review (QDRR) process. The Monitoring Team compliments the Facility and the pharmacy department, for its continued improvements.

- Positive Practices and Improvements Made
    - The Monitoring Team noted significant improvement with completion of the QDRRs. There has been significant improvement with the level of review of diagnostics, and assessment of metabolic syndrome. In all cases, the appropriate medical provider reviewed, signed, and concurred with the pharmacist's recommendations.
    - There was continued improvement with the Facility's medication variance process. The process ensured that all relevant departments, including nursing, pharmacy, and medical department were closely monitoring for medication variance, and potential medication variances. Medication variances, and potential medication variances, were stratified by type, severity, living area, department, and staff. Medication variances were tracked and trended, and were thoroughly discussed at the monthly medication variance meetings; when identified, appropriate action plans were developed and followed through to completion.
- Improvements Needed
    - The Facility must further enhance the QDRR process by ensuring that the pharmacist assesses and documents efficacy, and when necessary, recommends alternative treatments; clearly delineate the indication, and if the

indication for medications are appropriate; document potential serious and common side effects; carefully document a review of side effects.
    - Although the pharmacy had significantly improved on its review of polypharmacy, stat chemical restraints, usage of benzodiazepines, and anticholinergics, and metabolic syndrome, it must continue to enhance documentation of risks, and potential risks, associated with the use of polypharmacy, benzodiazepines, anticholinergics, and the risks associated with medications related to metabolic syndrome. Specific to review for stat chemical restraints, the pharmacy department must ensure a comprehensive and clinically appropriate review of the use of stat chemical restraints.

<u>Physical and Nutritional Management</u>
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 when not referred to the PNMT. These individuals were primarily reviewed by the IDT. PNMPs were noted to have become more comprehensive and provided staff with detailed strategies to mitigate associated PNM risks.

- Positive Practices and Improvements Made
    - New Employee training was comprehensive and DSSLC provided annual or refresher trainings that focused on preventing aspiration and providing proper transfer and lifting.
    - Since the last compliance review, DSSLC had revised a localized Physical and Nutritional Management Team (PNMT) policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the IDT.
    - PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers. Issues regarding consistency of the PNMPs across the various locations (i.e., MARs and "Me" books) appeared to have been resolved based upon the drawn sample.
- Improvements Needed
    - There was still not a clear consistent process in place to ensure staff were provided with 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 necessary training prior to working with the individual.
    - An adequate Physical and Nutritional Management Team (PNMT) was no longer in place as participation by the physical therapist and the dietitian was inconsistent.

- Although 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 change in PNM status were at a minimum reviewed/discussed as part of the IDT meeting.
- Monitoring of implementation did not occur regularly in all areas in which difficulties are likely to be provoked. Monitoring was not done on third shift.
- 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 that referral criteria and PNMT thresholds were integrated as part of the Integrated Health Care Plans (IHCPs). Additionally, indicators were not regularly reviewed by the IDT in an effort to determine if changes were needed to the PNMP or overall PNM plan of care.
- 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.

<u>Physical and Occupational Therapy</u>
DSSLC continued to show 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. Concerns were noted regarding the comprehensiveness of review and determination of services in the occurrence of a change in status.

- Positive Practices and Improvements Made
  - The vast majority of the assessments were noted to be comprehensive and address all generalized standards of a comprehensive assessment.
  -
- Improvements Needed
  - 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.
  - Indirect plans of care were not consistently implemented.
  - 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 was not fully implemented that allowed for the adequate monitoring of OT/PT supports.

Dental Services

The Facility maintained adequate staffing for its dental office, and that the Facility had effective professional, and support staff. There was substantial evidence demonstrating the annual dental examinations, dental hygiene, and restorative treatments were provided timely. The Facility did not, however, have effective processes in place to ensure necessary supports and services to provide oral healthcare at the living area.

- Positive Practices and Improvements Made
  - The Facility maintains a well staffed dental department, and there was evidence to indicate that services provided by the dental professionals, such as annual evaluations, dental hygiene, and restorative treatments, indicated that dental services are provided at the level of standard of care practice.
  - The Facility has an effective system for evaluating the quality of dental treatments.
- Improvements Needed
  - The Facility must enhance its policies and procedures for oral hygiene and suction toothbrushing, and develop and implement a process that assesses the efficacy of direct care staff provision of suction toothbrushing and oral hygiene at the living area.
  - The ISP process must ensure that all oral health related issues are addressed, including the condition of oral and dental health, necessary treatments, necessary supports and services, risks and benefits of oral and dental health treatments, and challenges associated with the provision of oral healthcare. The IRRF and PMNP must clearly delineate all necessary treatments, including frequency of treatments, associated risks, and monitoring parameters when providing oral healthcare supports.
  - Documentation practices for the provision of emergency dental services should be more comprehensive, by including documentation of follow-up appointments, and monitoring parameters for nursing and direct care staff to follow.
  - The Facility provides adequate TIVA resources, and that the Facility provides clinical monitoring before, during, and post sedation.
  - The Facility should adopt a mechanism to efficiently track and trend dental services, or to maintain an effective dental schedule. The Facility should also identify reasons for missed appointments, such as illness, other medical appointments, or hospitalizations, maladaptive behaviors, and system issues such as staff shortages, communication issues, and lack of transportation to assist in planning improvement actions.
  - The Facility needs to develop a process to monitor and assess possible adverse outcomes secondary to dental services, such as exacerbation of maladaptive behaviors, injuries, or pneumonia.

Communication

Overall, Speech Assessments showed significant improvement regarding comprehensiveness. DSSLC did a much better job identifying programs to help improve expressive and receptive language. Although programs may have shown improvement, implementation of communication programs remained low and staff knowledge of how to form effective communication with the individuals remained not evident at the home level.

- Positive Practices and Improvements Made
  - DSSLC was at full capacity with regards to Speech Pathologists and had recently opened another position for a Speech Therapy Assistant. All Therapists were board certified and licensed to practice in the state of Texas. All Therapists had evidence of participating in continuing education that was relevant to the field of practice.
  - Integration into the ISP had shown improvement as evidenced primarily by improved comprehensiveness of the PNMP.
- Improvements Needed
  - 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.
  - Concerns were noted however regarding Alternative and Augmentative communication (AAC) being readily available and utilized within the home environment.
  - Direct treatment plans did not provide clear measurable goals in which success could be determined.
  - DSSLC did not have a comprehensive monitoring system that covered the presence and condition of the device, implementation of the device, as well as SLP participation in care. DSSLC had recently developed a system that had the needed guidelines but the process was in its infancy and did not have sufficient and consistent data to determine compliance at this time.

Habilitation, Training, Education, and Skill Acquisition Programs

The Facility had invested considerable effort in improving the quality of services addressed by Section S of the Settlement Agreement. As a result, in some areas substantive progress had been achieved. In other areas, however, no progress was noted and at times, the Facility had regressed.

- Positive Practices and Improvements Made
  - Skill acquisition plans better reflected individual preferences.
  - Components of skill acquisition plans had improved modestly.
  - The percentage of individuals observed during monitoring to be functionally engaged had improved.
  - The percentage of assessment reports prepared for ISPs had improved.
  - The Facility continued to provide abundant leisure and training opportunities in the community.

- Improvements Needed
    - Almost two thirds of the skill acquisition plans reviewed by the Monitoring Team were not based upon adequate assessments or lacked adequate discussion in the ISP report.
    - A substantial number of skill acquisition programs continued to lack essential components, such as adequate behavioral objectives, sufficient trials, specific instructions for providing teaching, and plans for maintenance and generalization.
    - Numerous data collection forms for skill acquisition programs reflected poor compliance with training schedules, missing data, and data recording practices that did not match instructions in the skill acquisition program.

Most Integrated Setting

This Section was found to be not in compliance overall. A summary of noted progress included a continued relatively high number of referrals and transitions. The Facility was also to be commended for enhancing staffing resources sufficient to meet the additional demands resulting from its relatively high number of referrals and transitions.

- Positive Practices and Improvements Made
    - Fourteen individuals had transitioned to community living and there were 31 active referrals.
    - The Facility identified staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed.
    - The CLDP was reviewed with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living.
    - PMM Checklists were being completed in a timely manner and included visits to all sites at which the individual lived and worked/day activity, as required. The PMM Checklists reviewed in depth indicated that post move monitoring appeared to have been conducted in a thorough manner.
- Improvements Needed
    - DSSLC failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue its efforts toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
    - The IDT failed to identify consistently 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 address the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences.
    - CLDPs did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.

- The Facility did not yet consistently take assertive action on a continuing basis to ensure supports were implemented following transition, although there were examples in which the Facility did act to ensure appropriate supports were provided. Although there was progress in the rigor with which the PMM visit was completed, deficiencies remained due to a lack of adequate detail in the CLDP.
- The Facility reported one Alternate Discharge during the past six months. A discharge plan sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement was not provided. The IDT did not provide an adequate final summary of the individual's developmental, behavioral, social, health and nutritional status or adequately describe the key supports that the individual would need in the new setting.

Consent

This Section was not yet in compliance. A summary of noted progress included the Facility's continued innovative approaches in developing of alternatives to guardianship such as its Advocacy and Supportive Friendship programs. The Monitoring Team also commends the Facility for its initiative in incorporating formal choice and decision-making training in its self-advocacy efforts. Overall, the Facility had put into place a number of systems that will be important underpinnings once the Facility has developed the capacity to assess individuals' needs for guardianship and other decision-making supports.

- 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 (Integrated Risk Rating) process.
  - The Facility continued to implement its Guardianship Committee in a thoughtful and organized manner.
  - The Facility had made adjustments to its Advocacy, including implementation of a Supportive Friendship program.
  - The Monitoring Team also commends the Facility for its continuing initiative toward incorporating formal choice and decision-making training in its self-advocacy efforts.
- 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 the IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria. It was reported that such guidance was forthcoming in the near future.

Recordkeeping and General Plan Implementation

The Facility maintained a unified record for each individual. Records were generally accessible to staff who needed them, although the checkout process to identify where records were when not at the living unit was not consistently followed. The Facility maintained the level of completeness and compliance with Appendix D requirements as found at the last compliance visit.

- 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.
    - Active records contained most required documents.
    - The Facility had developed a crosswalk of policies against provisions of the Settlement Agreement for DADS policies and Facility policies, and reported 97% of provisions were addressed by at least one policy. This should help identify any further needs for policy development.
    - The record audit system is robust and comprehensive.
    - Audit findings for individual records are sent to staff responsible for making corrections. The Facility has a system for tracking corrections; although nearly all cleared items had been corrected, the Facility needs to be cautious and ensure all cleared items have been corrected.
    - The Facility has addressed some systemic issues with varying degrees of success.
- Improvements Needed
    - Improvement was needed in meeting requirements of Appendix D.
    - The checkout system was not used consistently.
    - A database was developed to track training on policies, but it needed revision, and tracking of training was being done by manual review of training sheets.
    - The Facility did not have a process in place for routine and periodic review of policies.
    - Staff could report that they used records in making decisions and could describe examples, but observations at interdisciplinary planning meetings (both in Facility audits and by the Monitoring Team) indicated use of records and information from records was variable.

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

| SECTION C: Protection from Harm-Restraints | |
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| Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. DSSLC Presentation Book (undated)<br>4. DADS Policy 001.1: Use of Restraint 4/10/12<br>5. DSSLC Policy CMGMT-20 Use of Restraint 2/1/13<br>6. Sample of staff training records (Sample C.2)<br>7. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 12/1/13<br>8. Restraint log for crisis intervention restraints 8/1/13 to 11/25/13<br>9. Restraint log for medical restraints 8/1/13 to 11/25/13<br>10. Restraint documentation files for sample (Sample C.1) of four crisis intervention restraints that occurred since the last review, including Restraint Checklist, Face-to-Face Assessment/Debriefing (FFAD), restraint monitor training records, restraint review documentation, Positive Behavior Support Plan (PBSP), Safety Plan for Crisis Intervention (SPCI) and Individual Support Plan Addendums (ISPAs) for Individuals #119 (2x), #413, and #616<br>11. Restraint documentation files for sample (Sample C.3) of medical restraint for Individuals #492 (11/14), #412 (10/21), #395 (10/9), #22 (9/4), #169 (10/28), #28 (11/8), #90 (10/29), #526, #134, #557, #313, #359, #749, #82, #583, #742, #150, #661, #192, #209, #335, #793, and #461<br>12. Sample of records associated with Individuals using abdominal binders (Sample C.4) for Individuals #654, #92, #507. #594, and #565<br>13. Restraint Trend Analysis 12/13<br>**People Interviewed:**<br>1. Trenton Berrie, BCBA, Section C Lead<br>2. Eight Direct Care Professionals (DCP's)<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 1/14/14<br>2. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 1/14/14 |
| | **Facility Self-Assessment:**<br>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.<br><br>For Section C, in conducting its self-assessment, the Facility:<br>▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed |

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| | monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff:<br>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).<br>o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews.<br>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.<br>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.<br>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).<br>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.<br>▪ 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.<br>▪ 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.<br>o Presented findings based on specific, measurable indicators.<br>o Measured the quality as well as presence of items.<br>o Did not distinguish data collected by the QA Department versus the program/discipline.<br>▪ The Facility rated itself as being in compliance with Provisions C.1, C.2, C.3, 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, C.2 and C.3. Because the Facility did not have any Individuals meeting the criteria of four or more restraints in a 30 day period Provision C.7 was not rated; in the last review most sub-sections of Provision C.7 were in compliance and had the Facility experienced four or more restraints in a 30 day period the Monitoring Team would have expected to find continued compliance. The lack of compliance with Provisions C.4 and C.5 was primarily attributable to deficient practices with respect to medical restraint. Restraint review practices required under Provision C.8 were not consistently detecting documentation errors and were not sufficiently robust in examining the circumstances leading up to restraint use. |

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| | 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.<br>▪ 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.<br>▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. |
| | **Summary of Monitor's Assessment:**<br>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 continued. This continued to be the case. 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.<br><br>Through interviews with Facility staff it was clear 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.<br><br>The Facility did not have any instances of use of Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB).<br><br>The Facility continued to conduct auditing of restraint documentation for every instance of restraint use, using a standardized monitoring tool. This usually provided the necessary data to identify practice and documentation discrepancies requiring administrative follow-up. Nevertheless, 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.<br><br>Review of Positive Behavior Support Plans confirmed that restraint was only being used for crisis intervention.<br><br>As in past reviews, inconsistent restraint monitoring by nursing staff was noted and needs to be aggressively addressed.<br><br>The Facility had made progress in complying with Settlement Agreement requirements associated with medical restraint. Still lacking was the consistent development of strategies and programs to minimize the need for medical restraint.<br><br>The Facility's restraint review practices 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. |

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| | Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. The Monitoring Team review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), did not discover any use of prone restraint. |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The Facility reported the following with respect to restraint use:<br><br>
<table>
<tr><th>Type of Restraint</th><th>1/1/13 to 6/30/13</th><th>7/1/13 to 12/31/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>7</td><td>8</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>0</td><td>1</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>2</td><td>1</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>9</td><td>10</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>5</td><td>8</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>1</td><td>2</td></tr>
<tr><td>Medical/dental restraints</td><td>516*</td><td>404</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>351</td><td>285</td></tr>
</table>
*A single Individual recently admitted to the Facility accounted for this unusually high number.<br><br>
The last compliance report noted that data on use of restraints for medical and dental reasons provided in response to document requests for Sections C and J were not consistent and recommended the Facility periodically audit those data. For this review, the data provided for those two Sections covered different time periods, so the Monitoring Team could not assess whether they were consistent.<br><br>
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 continued. This 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 had over 250 Individuals with Positive Behavior Support Plans yet very limited use of restraint. The continued low utilization of crisis intervention restraint suggests the Facility continues to be very proactive in providing effective supports.</td><td>Substantial Compliance</td></tr>
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| | | Sample C.1 consisted of restraints between 8/1/13 and 11/15/13 when the Facility prepared its response to the Monitoring Team's document request. This consisted of four restraints. In reviewing 100% of crisis intervention restraints (n=4) the Monitoring Team did not find any instance of use of restraint for the convenience of staff or in a clinically unjustifiable manner.<br><br>Through interviews with Facility staff it was clear 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 low 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.<br><br>The continued infrequent use of crisis intervention restraint, along with data presented in this report, led the Monitoring Team to believe that restraint is used in a clinically justifiable manner and not for the convenience of staff. Additionally, the Monitoring Tools used by the DSSLC to measure compliance with this part of the Settlement Agreement (SA) for the four episodes of crisis intervention restraint showed compliance with this specific requirement.<br><br><u>Prone Restraint</u><br>Based on Facility policy review, prone restraint was prohibited.<br><br>Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified.<br><br>A sample, referred to as Sample C.1, was selected. (This was a 100% sample of the four crisis intervention restraints since the last review).<br><br>Based on a review of the restraint records for individuals in Sample C.1 involving three individuals, none (0%) showed use of prone restraint.<br><br>Based on questions with eight direct support professionals, all (100%) were aware of the prohibition on prone restraint. These eight staff were all from residential areas where many Individuals had Positive Behavior Support Plans (PBSPs) and where restraint had occurred.<br><br><u>Other Restraint Requirements</u><br>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 | |

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| | | 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.<br><br>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:<br><br>In four of the four records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others.<br><br>For the four restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that four (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment.<br><br>In four 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.<br><br>Facility policies do identify a list of approved restraints. Based on the review of four restraints, involving three Individuals, four (100%) were approved restraints.<br><br>In four of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment.<br><br>The Facility continued to conduct 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.<br><br>At the time of the review no Individuals were the subject of protective mechanical restraint for self-injurious behavior (PMR-SIB).<br><br>The Facility had 33 Individuals using abdominal binders as support for enteral feeding. The Monitoring Team reviewed physician orders and ISPs for Sample C.4 and found physician orders and documented IDT discussion validated the use of abdominal binders 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 | |

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| | | Individuals confirmed appropriate use of abdominal binders and that these were not used due to behavior of the individuals.<br><br>Additionally, the Facility had promulgated guidelines to follow in regard to the use of abdominal binders, among other supports such as grip-lock tape and tank tops, to support the placement of enteral feeding tubes in order to reduce the chance of accidental dislodgement as well as to reduce chafing and other skin integrity issues. As such, teams could adopt abdominal binders as a postural support. The Facility guidelines also stated that if an individual engages in challenging behavior such as intentionally dislodging the feeding tube, other less restrictive practices such as an increased Level of Supervision (LOS) must be attempted prior to implementing a protective-mechanical restraint. Thus, an individual may engage in behavior that dislodges a tube and wear an abdominal binder, with an LOS to reduce the risk of intentional dislodgment as a support to reduce skin integrity issues and accidental dislodgment. As an additional clarification, the term "intentional dislodgement" used in some documentation was described to the Monitoring Team as "intentional behavior causing dislodgment." The Facility acknowledged that if an individual would engage in purposeful, functional behavior that could lead to dislodgment and injury to herself as a byproduct of that behavior, then the use of an abdominal binder, even for a function of sensory stimulation/relief, and even if paired with a level of supervision for the same purpose, would be considered a protective mechanical restraint. The Monitoring Team did not identify any use of abdominal binders that would be considered a restraint.<br>Based on this review this Provision was in substantial compliance. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others. | The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. Nevertheless, because the Facility only had four crisis intervention restraints all four were reviewed.<br><br>The restraint records involving the three Individuals in Sample C.1 were reviewed. Records for all 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.<br><br>Based on this review this Provision is in substantial compliance. | 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 | The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement.<br><br>Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: | Substantial Compliance |

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| | 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. | • Policies governing the use of restraint;<br>• Approved verbal and redirection techniques;<br>• Approved restraint techniques; and<br>• Adequate supervision of any individual in restraint.<br><br>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.<br><br>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:<br>• 24 of the 24 (100%) had completed training in RES0105 Restraint Prevention and Rules within the last 12 months.<br>• 24 of the 24 (100%) had completed PMAB training within the past 12 months.<br><br>The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for DSSLC employees:<br>1. 99% RES0105 Restraint: Prevention and Rules for Use at MR Facilities<br>2. 99% RES0110 Applying Restraint Devices<br>3. 98% PMA0320 – PMAB Basic<br>4. 98% PMA0400- PMAB Restraint<br>5. 98% PMA0700 –PMAB Prevention<br>6. 98% PBS0100 – Positive Behavior Support<br>These compliance percentages were sufficient to demonstrate substantial compliance with the training component of this provision.<br><br>In order to evaluate staff knowledge in the area of restraint, eight Direct Care Professionals were asked a series of questions. The eight staff were selected by the Monitoring Team 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 Assistant Director of Programs and the Facility's Director of Residential Services. Consequently, for each question, responses were subjected to 24 evaluations (eight individuals' times three raters).<br><br>Based on responses to questions, nine direct support professionals provided satisfactory responses to the following questions as follows:<br>• "Policies governing the use of restraint require that restraint should only be used if the Individual poses a _____and after_____." Twenty of 24 responses were | |

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| | | evaluated as satisfactory (83%);<br>• "Describe an example of a verbal redirection technique." Twenty-four of 24 responses were evaluated as satisfactory (100%);<br>• "Describe two restraint techniques approved for use at the Facility." Twenty-one of 24 responses were evaluated as satisfactory (88%);<br>• "What level of supervision is usually required when an Individual is in restraint?" Twenty-four of 24 responses were evaluated as satisfactory (100%); and,<br>• "Under what circumstances is it OK to use prone restraint?" All 24 responses were evaluated as satisfactory (100%).<br>Overall 113 of a possible 120 ratings (5 questions times 24 possible ratings for each question) were rated as acceptable for an overall rating of 94%.<br><br>In four 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.<br><br>Based on this review this Provision was in substantial compliance. | |
| C4 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is 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 four restraint records (Sample C.1), in four (100%) there was evidence that documented that restraint was used as a crisis intervention.<br><br>In review of the three Positive Behavior Support Plans for Sample C.1, in three (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).<br><br>In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention.<br><br>The Facility did not maintain a "Do Not Restrain" list. In one of four restraint records reviewed (25%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders or ISP as documented on the form used by the facility to individually document restraint considerations/restrictions. This was the case for restraint of Individual #413.<br><br>In its last report the Monitoring Team noted that the Facility had taken several positive steps since the last review to ensure that every Individual was assessed by the physician | Noncompliance |

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| | | to determine if any medical conditions would require modification in restraint procedures in order to keep the Individual safe. This was to be recorded on a form, for each Individual, titled "Considerations for Implementing Restraint." This form was revised in June, 2013. Consistent implementation of this process as demonstrated for this review had not occurred.<br><br>In reviewing 22 ISPs for individuals for whom restraint had been used for the completion of medical or dental work:<br>• Six (27%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent);<br>• None (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. | |
| C5 | Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital | 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.<br><br>Based on review of restraint and training records, of the staff at the Facility who performed the duties of a restraint monitor for the restraints in SamplemC.1 all (100%) had successfully completed the required 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. The required training included:<br>1. ABU0100 Abuse and Neglect<br>2. PMA0320 PMAB Basic<br>3. PMA0400 PMAB4: Restraint<br>4. PMA0700 PMAB7: Prevention<br>5. CPR0100 CPR Basic<br>6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities<br>7. RES0110 Applying Restraint Devices<br>8. PBS0100 Positive Behavior Support<br><br>Based on a review of four restraint records (Sample C.1), a face-to-face assessment was conducted: 1) in four (100%) by an adequately trained staff member, 2) in four (100%), the documentation showed that an assessment was completed of the application of the restraint, and, 3) in four (100%), the documentation showed that an assessment was completed of the consequences of the restraint.<br><br>In three of four (75%) restraints the restraint monitor was at the site of the restraint within 15 minutes. This was not the case for restraint of Individual #413. | Noncompliance |

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| | 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. | There were no instances of crisis intervention restraint where a physician had ordered an alternative monitoring schedule.<br><br>Based on a review of four restraint records for restraints that occurred at the Facility, there was documentation that a licensed health care professional:<br>• Conducted monitoring at least every 15 minutes from the initiation of the restraint in two of four (50%) of the instance of restraint. Records that did not contain documentation of this included:<br>o Individual #119: On 9/18/13 at 2300 p.m., Individual #119 was administered a chemical restraint. Monitoring was initiated at the time the chemical restraint was administered but was not conducted every 15 minutes as required.<br>o Individual #413: On 9/12/13 at 12:20 a.m., physical restraint was applied. Monitoring was not performed until 0130 (1:30 a.m.).<br>• Monitored and documented vital signs in one of four (25%) instances of restraint. Records that did not contain documentation of this included:<br>o Individual #119: On 9/18/13 at 2300 (11:00 p.m.), Individual #119 was administered a chemical restraint. Two issues of noncompliance were found. First, vital signs were not assessed every 15 minutes according to policy after the initial assessments at 2300 and 2315 (11:15 p.m.). Vital signs were attempted/taken at intervals from 2300 (11:00 p.m.) through 1100 (11:00 a.m.) as printed on the RN/LVN Post-Med Monitoring – Chemical only, Crisis Intervention Restraint Checklist, i.e., 15minutes, 30 minutes, 45 minutes, and so forth. Even using the wrong form, assessing vital signs should have occurred every 15 minutes; however, the nurse apparently misunderstood the instructions for taking vital signs every 15 minutes for pre-Treatment and Post-Sedation monitoring and instead attempted to take vitals at approximately the 15 minute, 45 minute, and 90 minute intervals. Second, the nurse documented several times during the interval charting of vital signs that after three attempts to obtain vital signs Individual #119 refused to allow vital sign monitoring/assessments. During the refusals there was no documentation that objective observations were made for respiratory distress. Full sets of vital signs were documented at 0345 (3:45 p.m.), 0715 (7:15 p.m.), and 1100 (11:00 a.m.), which appeared to show they had returned to baseline.<br>o Individual #119: On 10/1/13 at 8:46 p.m. (2046), physical restraint was applied at the wheelchair shop. The nurse documented that Individual refused to allow vital signs taken. There was no documentation that objective observations were made for respiratory distress. A full set of vital signs was documented at 2250 (10:50 p.m.). | |

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| | | o Individual #413: On 9/12/13 at 12:20 a.m., physical restraint was applied. Vital sign monitoring was not performed until 0130 (1:30 a.m.). However, the nurse was not notified of the restraint episode until 1:27 a.m.<br>• Monitored and documented mental status in three of four (75%) instances of restraint (although for these three, documentation of mental status should have included objective signs). Documentation of this included:<br>o Individual #119: On 9/18/13 at 2300 p.m., Individual #119 was administered a chemical restraint. Mental status was monitored at the frequency described above for vital sign monitoring. Mental status was documented and described as agitated, calm, resting, and asleep.<br>o Individual #119: On 10/1/13 at 8:46 p.m. (2046), physical restraint was applied at the wheelchair shop. Mental status was documented and described as alert, responsive and level of consciousness normal.<br>o Individual #413: Individual #413: On 9/12/13 at 12:20 a.m., physical restraint was applied. Mental status monitoring was not performed until 0130 (1:30 a.m.). Mental status was documented and described as awake and alert. However, the nurse was not notified of the restraint episode until 1:27 a.m.<br>o Individual #616: On 10/30/13 at 5:12 p.m., physical restraint was applied. Mental status documented timely. The documentation described mental status as alert, oriented, and compliant with the RN but was angry with other staff.<br>• There were no injuries documented related to the use of the restraints in the four restraint records reviewed.<br><br>As suggested at the last compliance review, if the individual's behavior made it difficult to conduct this monitoring, the licensed healthcare 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. Terms such as "alert, responsive, and level of consciousness normal" should be clarified with description of the behavior that indicates this status.<br><br>In order to meet compliance with policy it is essential that staff notify the nursing staff within 30 minutes of the application of restraints. | |

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| | | Sample C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 20% 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.<br>• In 18 out of 22 (82%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and<br>• In five out of 22 (23%), the physician specified the type of monitoring required if it was different than the facility policy.<br>• In five out of 22 of the medical restraints (23%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed.<br><br>As reported in Provision Q, documentation did not provide evidence that the dental office did not provide post-sedation monitoring orders, such as monitoring and reporting parameters, to be completed at the living area, by direct care staff. The Monitoring Team noted that the standardized form used by direct care staff to communicate post-monitoring effects, was blank for each example reviewed. However, monitoring at the Infirmary following Total Intravenous Anesthesia (TIVA) was exemplary.<br><br>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 | A sample (Sample C.1) of four 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:<br>• In three (75%), continuous one-to-one supervision was provided. This was not the case for Individual #413; ;<br>• In four (100%), the date and time restraint was begun;<br>• In four (100%), the location of the restraint;<br>• In none (0%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. 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 all four restraints information addressing this was either overly general or nonexistent.<br>• In none (0%), the actions taken by staff prior to the use of restraint to permit adequate review per Provision C.8. Refer to above paragraph.<br>• In four (100%), the specific reasons for the use of the restraint;<br>• In four (100%), the method and type (e.g., medical, dental, crisis intervention) of | Noncompliance |

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| | 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. | restraint;<br>• In four (100%), the names of staff involved in the restraint episode;<br>• In three (75%) observations of the individual and actions taken by staff while the individual was in restraint, including at release. This was not the case for restraint of Individual #119 on 9/18/13.<br>• All four restraints were of short duration, the longest being nine minutes.<br>• In three (75%), the level of supervision provided during the restraint episode. This was not the case with restraint of Individual #413;<br>• In three (75%), the date and time the individual was released from restraint. For restraint of Individual #119 (9/18/13) the restraint documentation contained conflicting data; and<br>• In three (75%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. For restraint of Individual #413 the restraint documentation contained conflicting data.<br><br>In a sample of four records (Sample C.1), restraint debriefing forms had been completed for four (100%); however, data was not always consistent with data recorded on the Restraint Checklist. This was the case for Individual #413 with regard to injury related data recorded on the Restraint Checklist being inconsistent with data recorded on the Debriefing form. Because of these inconsistent data the compliance rate is three of four (75%).<br><br>A sample of 22 Individuals subject to medical restraint was reviewed (Sample C.3), and in five (23%), there was evidence that the monitoring had been completed as required by the physician's order.<br><br>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; | This Provision was rated as in substantial compliance in the last review, however; according to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not rated |

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| | (b) review possibly contributing environmental conditions; | This Provision was rated as in substantial compliance in the last review, however; according to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not Rated |
| | (c) review or perform structural assessments of the behavior provoking restraints; | This Provision was rated as in substantial compliance in the last review, however; according to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not Rated |
| | (d) review or perform functional assessments of the behavior provoking restraints; | This Provision was rated as in substantial compliance in the last review, however; according to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not Rated |
| | (e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP; | This Provision was rated as in substantial compliance in the last review, however; according to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not Rated |
| | (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 | This Provision was rated as noncompliance in the last review. According to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not Rated |

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| | settings and fully as written upon each occurrence of a targeted behavior; and | | |
| | (g) as necessary, assess and revise the PBSP. | This Provision was rated as in substantial compliance in the last review, however; according to Facility documentation, during the six-month period prior to this onsite review, no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated. | Not Rated |
| C8 | Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate. | 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 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". This was the case with restraint of Individuals #119 (10/1/13) and #616.<br><br>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.<br><br>Documentation related to Facility review of four 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:<br>• In three (75%), 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 #119 (9/18/13).<br>• In four (100%), the review by the IMRT occurred within three business days of | Noncompliance |

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| | | the restraint episode and this review is documented by date entry on the Restraint Checklist and review of IMRT minutes.<br>• In four (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.<br>• In none (0%), the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. 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 specific factors existed that, if modified, might prevent future use of restraint with the individual, including review of the circumstances immediately preceding the events that led to the initiation of behavioral intervention techniques (resulting in restraint).<br>• In three (75%), referrals were made to the team, as appropriate. This was not the case for Individual #119; and<br>• Of the three referred to the team, in three (100%) appropriate changes were made to the individuals' ISPs and/or PBSPs.<br><br>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.<br><br>The Facility reported that it subjected all crisis intervention restraints to the more rigorous review elements required under Provision C.7. Documentation provided to the Monitoring Team was inconsistent in this regard.<br><br>Based on this review the Facility was not in compliance with this provision. | |

| SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management | |
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| Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. Settlement Agreement (SA) Section D Presentation Book (undated)<br>4. DADS Policy 02.1 Protection From Harm – Abuse, Neglect, and Exploitation 12/3/12<br>5. DADS Policy 02.3 Incident Management 11/20/12<br>6. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 11/13/13<br>7. DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 11/13/13<br>8. Sample of Employee Training Records – Sample C.2<br>9. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 12/1/13<br>10. Allegation, Injury, and UIR Trend Report 12/13<br>11. Training records for investigators hired since the last review<br>12. DFPS case log 8/1/13 to 12/15/13<br>13. OIG case log 8/1/13 to 12/15/13<br>14. Serious Incident log 8/1/13 to 12/15/13<br>15. Witnessed Injury log 8/1/13 to 12/15/13<br>16. List of the most frequently injured Individuals 8/1/13 to 12/15/13<br>17. Discovered Injury log 8/1/13 to 12/15/13<br>18. Peer caused injury log 8/1/13 to 12/15/13<br>19. 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 42840831, 42842994, 42852930, 42854330, 42857818, 42869961, 42877226, 42883747, 42898792, 42907795, 42911455, 42925051, 42938396, and 42938396. This sample was selected from the document the Facility submitted listing the allegations/investigations completed since the last review. The sample was 20% of reported investigations initiated and completed since the last review and represented investigations that resulted in confirmed, unconfirmed, inconclusive, and administrative referral findings.<br>20. Sample D.2: included a sample of Facility-only investigation reports selected from the document the Facility provided listing investigations completed since the last review consisting of UIRs 13-266, 13-270, 14-010, 14-018, 14-032, 14-044, 14-048, 14-049, 14-062. The sample was 20% of reported investigations initiated and completed since the last visit and included serious injuries and other serious incidents.<br>21. Sample C.3: the sample of Individual Support Plans (ISPs) reviewed. These were the ISPs that were part of Sample C.1 (four crisis intervention restraints).<br>22. List of employees who failed to report or were late in reporting since the last review<br>23. Under Reporting Audit reports August - November, 2013<br>24. QA/QI committee meeting minutes: August - December, 2013<br>**People Interviewed:** |

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| | 1. Nancy Condon, Facility Director<br>2. Deb Salsman, Director of Incident Management<br>3. Jeron Dotson, Incident Management Coordinator<br>4. Nora Brookins, QA Program Auditor<br>5. Eight Direct Care Professionals (DCP's)<br>**Meetings Attended/Observations:**<br>1. Incident Management Team (IMRT) 1/14/14<br>2. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 1/14/14 |
| | **Facility Self-Assessment:**<br>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.<br><br>For Section D, in conducting its self-assessment, the Facility:<br>• 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:<br>o The monitoring/audit tools the Facility used to conduct its self-assessment included the Section D DADS Monitoring Tool<br>o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews.<br>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.<br>o The monitoring/audit tools did have adequate written instructions/guidelines to ensure consistency in monitoring and the validity of the results.<br>o The following staff/positions were responsible for completing the audit tools: Incident Management Coordinator and IMC Investigators.<br>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).<br>o Adequate inter-rater reliability had not been established to validate the monitoring findings for Section D.<br>• The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:<br>o Presented findings based on specific, measurable indicators and used these data in initiating corrective actions |

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| | ○ Measured the quality as well as presence of items.<br>• The Facility rated itself as being in compliance with 19 of the 22 Provisions of Section D. The Provisions the Facility did not rate itself as in substantial compliance included Provisions D.3.f, D.3.h, and D.4. The Monitoring Team found the Facility to be in compliance with 16 Provisions. These included the three Provisions for which the Facility self-assessed noncompliance and three Provisions where the Facility self-assessed compliance and the Monitoring Team did not. These were: 1) Provision D.2.a (allegations/serious incidents being reported within required timeframes), 2) Provision D.3.g (not all investigations are thorough and complete), and 3) Provision D.3.i (disciplinary and programmatic actions following an investigation are not monitored closely by the Facility Incident Management Review Team – IMRT).<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve continued compliance.<br>• Actions were reported as completed or in progress.<br>• 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<br>• The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. There were three Provisions the Facility self-assessed as in compliance that were not. The Facility Action Plan needs to address these provisions. |
| | **Summary of Monitor's Assessment:**<br>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 16 Provisions.<br><br>The Provisions where the Facility self-assessed compliance and the Monitoring Team did not included: 1) Provision D.2.a (allegations/serious incidents being reported within required timeframes), 2) Provision D.3.g (not all investigations are thorough and complete), and 3) Provision D.3.i (disciplinary and programmatic actions following an investigation are not monitored closely by the Facility Incident Management Review Team – IMRT).<br><br>As noted in the last report, the Facility had most of the administrative systems in place to achieve compliance with Section D but needed 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.<br><br>Late reporting of allegations of abuse, neglect, and serious incidents still occurs too often.<br><br>The number of confirmed findings of abuse and neglect had increased from 11 to 15, comparing the two most recent six-month periods.<br><br>In its last report the Monitoring Team highlighted three recently initiated actions: 1) taking additional |

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| | 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) reinforcing abuse and neglect reporting. All three processes remained in place.<br><br>The thoroughness and completeness of Facility review of facility investigations of UIRs was still not sufficient to ensure content of investigations was thorough and complete and that the report is accurate and complete.<br><br>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.<br><br>Improvement is needed in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs). |

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| D1 | Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | 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 | 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 | Noncompliance |

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| | exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting. | 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 collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.<br><br>According to data the Facility provided to the Monitoring Team, the numbers of abuse/neglect/exploitation allegations for the past two six-month periods were: | |

| | 1/1/13 to 6/30/13 | 7/1/13 to 12/31/13 |
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| Total abuse allegations | 75 | 58 |
| Physical | 56 | 47 |
| Verbal/Emotional | 19 | 11 |
| Abuse substantiated | 7 | 12 |
| Physical | 6 | 7 |
| Verbal/Emotional | 1 | 5 |
| Abuse inconclusive | 7 | 1 |
| Physical | 6 | 1 |
| Verbal/Emotional | 1 | 0 |
| Total neglect allegations | 32 | 39 |
| Neglect substantiated | 4 | 3 |
| Neglect inconclusive | 0 | 0 |
| Total exploitation allegations | 3 | 1 |
| 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 six-month periods included:

| | 1/1/13 to 6/30/13 | 7/1/13 to 12/31/13 |
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| Deaths | 4 | 4 |
| Serious Injuries | 27 | 22 |
| Sexual Incidents | 0 | 1 |
| Suicide Threat (credible) | 1 | 5 |
| Unauthorized Departure | 5 | 7 |
| Choking | 7 | 9 |
| Other | 6 | 4 |

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| | | 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 were consistent with the Settlement Agreement requirements.<br><br>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.<br><br>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.<br><br>In order to evaluate staff knowledge in the area of abuse and neglect eight Direct Care Professionals were asked a series of questions. The eight staff were selected by the Monitoring Team 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 Assistant Director of Programs, and the Facility's Director of Residential Services. Consequently, for each question responses were subjected to 24 evaluations (eight staff times three raters).<br><br>Based on responses to questions, eight direct support professionals provided satisfactory responses to the following questions as noted:<br><br>"Describe the reporting procedure and timeframe when abuse/neglect is suspected." Eleven of 24 responses were evaluated as satisfactory (46%). Most responses rated as unsatisfactory were because the response did not describe both the procedure and timeframe for reporting.<br><br>"Describe the reporting procedure and timeframe for other serious incidents." Eighteen of 24 responses were evaluated as satisfactory (75%). Most responses rated as unsatisfactory were because the response did not describe both the procedure and timeframe for reporting.<br><br>The above data suggests the Facility needs to continue focusing efforts on improving staff | |

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| | | knowledge with respect to proper reporting of abuse, neglect, and serious incidents. This likely contributes to the problem the Facility identified in its self-assessment (and confirmed by the Monitoring Team) of late reporting. In its self-assessment the Facility noted that in 6% of 140 UIRs examined late reporting was identified. This represented 11 instances of late reporting.<br><br>The Facility continued to maintain 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 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).<br><br>Based on a review of the 14 investigation reports included in Sample D.1:<br>▪ For four, the date/time of the incident was unknown so it could not be determined if it was reported in accordance with policy.<br>▪ Of the remaining 10, six (60%) 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 42869961, 42907795, 42911455, and 42925051. The Facility self-assessment, which reviewed 140 incidents, reported a late reporting rate of 6%, much lower than the 40% noted from the Monitoring Team's sample. This may be because the Facility reported that for the most part allegations were reported to DFPS once they became known to the Facility IMC office. The IMC office would view it as a late report if it was clear a specifically named individual staff person did not report the incident within the timeframe established by policy and the SA. Reporting of allegations of abuse and neglect, and other serious incidents, is the responsibility of every staff person at the Facility. When evidence is discovered in the course of reviewing an allegation or serious incident that a staff person, even if unknown, was or should have been aware of an incident, and did not report it until sometime later (more than one hour), or at all, that should be considered late reporting.<br>▪ Of the remaining 10, six (60%) 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 42869961, 42907795, 42911455, and 42925051.<br>▪ For the 11 instances of late reporting noted by the Facility, evidence provided to the Monitoring Team confirmed recommendations for corrective action occurred in nine cases (82%). The other two cases were pending a final OIG report.<br>▪ For the four investigations noted by the Monitoring Team that were reported | |

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| | | late there was no evidence of follow-up on the part of the Facility as they did not identify the late reporting in their review of the investigations in three of the four cases. The exception was 42907795.<br><br>Based on a review of nine investigation reports included in Sample D.2:<br>▪ Eight (89%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. UIR 14-048 did not.<br>▪ Eight (89%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. UIR 14-048 did not.<br><br>The Facility did have a standardized reporting format. Based on a review of 24 investigation reports included in Samples D.1 and D.2, 25 (100%) contained a copy of the report utilizing the required standardized format and were completed fully.<br><br>Based on this review this Provision was not in substantial compliance. | |
| | (b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| | (c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |

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| | completion of such training. | | |
| | (d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial 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. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | 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. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| | (g) Procedures for referring, as appropriate, allegations of | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The | Substantial Compliance |

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| | abuse and/or neglect to law enforcement. | substantial compliance finding from the last review stands. | |
| | (h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | In its last report the Monitoring Team noted that Facility policy CMGMT-01B (Incident Management) did not define sufficient procedures to audit whether significant injuries are reported for investigation. The Monitoring Team suggested that this procedure should be incorporated in to Facility policy. This had not occurred. Nevertheless, the Facility reported it was following the DADS issued procedure for these audits.<br><br>The DADS procedure referenced above establishes a general framework for the review and investigation of injuries. This procedure reports the following as its purpose:<br>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).<br>2. The proper coding of injuries to residents<br>3. Decreasing injuries of known or unknown source or origin<br>4. Ensuring residents remain free from abuse, neglect, or exploitation<br>5. Compliance with significant injury audit requirements D2i of the Settlement Agreement.<br><br>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 | Substantial Compliance |

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| | | 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 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.<br><br>The Facility had not as yet incorporated the above elements of State policy in to Facility policy.<br><br>Audits conducted pursuant to this Provision should include at a minimum procedures that include:<br>1. 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. The Facility practices reviewed by the Monitoring Team validate that this is part of the Facility's D2i audit process.<br>2. 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. The Facility practices reviewed by the Monitoring Team validate that this is part of the Facility's D2i audit process.<br>3. 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 Facility practices reviewed by the Monitoring Team validate that this is part of the Facility's D2i audit process. This occurs at a monthly trends meeting attended by executive level staff, most of whom also are members of the QAQI Council.<br><br>The audit procedure required by DADS had been in place at the Facility and was being administered correctly. The audits conducted of sampled Individuals were sufficient to determine whether significant resident injuries had been reported for investigation. The | |

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| | | audits reviewed by the Monitoring Team included the period August – November, 2013 and included 32 records. No significant resident injuries were detected by these audits; however, issues with injury reporting and documentation were detected with 12 (38%) of the records. The Facility initiated immediate corrective action in each case.<br><br>This Provision was in substantial compliance. | |
| D3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough 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. | Because the Facility was in substantial compliance with this Provision for more than three consecutive reviews the parties agreed the Monitoring Team would not monitor this provision unless new investigators had been hired in which case their training records would need to be reviewed by the Monitoring Team. The Facility had hired three new investigators since the last review. Their training records were reviewed and were satisfactory. The substantial compliance finding from the last review stands. | Substantial Compliance |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| | (c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |

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| | to interfere with such investigations. | | |
| | (d) Provide for the safeguarding of evidence. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.<br><br>The Monitoring Team remains concerned that an important element of State and Facility policy was not being followed. This policy reads "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 been interviewed". 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. 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**.** To the Facility's credit it continued its initiative noted in the last review to protect the integrity of testimonial evidence by implementing a "Testimonial Evidence Acknowledgment Form" where staff sign an acknowledgement that they are not to discuss the circumstances around an investigation with other staff. | Substantial Compliance |
| | (e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. | Based on Facility policy CMGMT-01B (Incident Management) investigations of serious incidents:<br>▪ Were to commence within 24 hours or sooner, if necessary;<br>▪ Were to be completed within 10 calendar days of the incident;<br>▪ 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<br>▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action.<br><br>To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations: | Substantial Compliance |

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| | | • Fourteen of 14 (100%) 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 (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.<br>• Twelve of 14 (86%) were completed within 10 calendar days of the incident, including sign-off by the supervisor;<br>• 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.<br>• Therefore, 14 of 14 (100%) were either completed within 10 days or received an appropriate extension.<br>• 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.<br>• DFPS concerns and recommendations for corrective action were included in two investigation reports and were appropriate to address issues identified by the DFPS investigator.<br><br><u>Facility Investigations (Sample D.2)</u><br>The following summarizes the results of the review of Facility investigations of serious incidents:<br><br>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.<br><br>Six of nine (67%) were completed within 10 calendar days of the incident (or had an approved extension), including sign-off by the supervisor with documentation of the | |

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| | | extraordinary circumstances that necessitated the extension. UIRs 13-270, 14-032, and 14-062 did not. In each case an extension form was prepared and approved but the reason for the extension request did not represent "extraordinary circumstances." Statements such as "additional time for IDT to work on recommendations" or "additional investigation into safety issues initiated after return from hospital" do not represent extraordinary circumstances preventing the investigation from being closed. These would ordinarily be considered as appropriate post investigation follow-up activities. These extensions did not effect in any material way the conclusions reached in the investigations or delay planned post investigation follow-up.<br><br>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.<br><br>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.<br><br>All 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.<br><br>Based on this review this Provision was in substantial compliance. | |
| | (f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a | Based on the Monitoring Team 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.<br><br>The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>• 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 42852930 (administrative referral) the investigator determined the allegation did not meet the definition of neglect even though earlier in the document the investigator states the client could have easily fallen off the bathing table while left unattended by staff. Such a fall could very well have resulted in a serious injury. Because of the clear potential for serious injury this incident should have been investigated as an allegation of neglect. For case 42925051 (inconclusive | Noncompliance |

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| | 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. | physical abuse) the investigation conclusion states "there was not enough evidence to determine if John Doe caused the injury to the lip, and if so, if it was intentional." Evidence in the investigation report suggests with a high degree of likelihood that John Doe caused the injury but a determination as to whether the physical interaction was intentional was unclear. It would appear that a more appropriate investigation conclusion would be that John Doe did in fact cause the injury but there was insufficient evidence to determine whether what occurred was intentional or an accident. This, by the way, is what the Facility's follow-up investigation determined.<br>• The report utilized a standardized format that set forth explicitly and separately:<br>o In 14 (100%), each unusual/serious incident or allegations of wrongdoing;<br>o In 14 (100%), the name(s) of all witnesses;<br>o In 14 (100%), the name(s) of all alleged victims and perpetrators;<br>o In 14 (100%), the names of all persons interviewed during the investigation;<br>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;<br>o In 14 (100%), all documents reviewed during the investigation;<br>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;<br>o In 14 (100%), the investigator's findings; and<br>o In 13 (93%), the investigator's reasons for his/her conclusions. Refer to case 42852930 above.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>• In five out of nine investigations reviewed (56%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. UIR 14-048 was a discovered serious injury categorized as "determined cause." The investigation contained insufficient evidence to make a determination of cause. The incident occurred in an area of the home covered by video cameras. It was unclear if video evidence was reviewed and if it was a statement to this effect was not included in the analysis of findings/causes, issues section of the UIR. For UIRs 13-266, 13-270, and 14-010 not all staff identified in the "staff involved" section of the UIR were interviewed; therefore, these investigations cannot be considered thorough and complete. | |

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| | | • The report utilized a standardized format that set forth explicitly and separately:<br>o In nine (100%), each unusual/serious incident or allegations of wrongdoing;<br>o In nine (100%), the name(s) of all witnesses (staff involved);<br>o In nine (100%), the name(s) of all alleged victims and perpetrators;<br>o In nine (100%), the names of all persons interviewed during the investigation;<br>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;<br>o In nine (100%), all documents reviewed during the investigation;<br>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;<br>o In nine (100%), the investigator's findings; and<br>o In eight (89%), the investigator's reasons for his/her conclusions. UIR 14-048 was a discovered serious injury categorized as "determined cause." The investigation contained insufficient evidence to make a determination of cause. The incident occurred in an area of the home covered by video cameras. It was unclear if video evidence was reviewed and if it was a statement to this effect was not included in the analysis of findings/causes, issues section of the UIR.<br>• Monthly audits of a sample of UIRs are conducted by Facility QA staff. The Monitoring Team reviewed six and noted these audits detected problems similar to those identified by the Monitoring Team in its review of Sample D.2.<br><br>Based on this review the Facility was 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 | 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.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ The DFPS investigations in Sample D.1 did meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f;<br>▪ 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. | Noncompliance |

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| | shall be addressed promptly. | ▪ 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.<br>▪ For one 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, the Facility did not note the problems with the investigation and/or report for UIR 13-274, and did not return the investigation to DFPS for reconsideration.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ Nine of nine (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation.<br>▪ 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.<br>▪ 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.<br>• For the nine investigations noted above, the Monitoring Team identified deficiencies in four (44%). The supervisory review did not appear to address these deficiencies. UIR 14-048 was a discovered serious injury categorized as "determined cause." The investigation contained insufficient evidence to make a determination of cause. The incident occurred in an area of the home covered by video cameras. It was unclear if video evidence was reviewed and if it was a statement to this effect was not included in the analysis of findings/causes, issues section of the UIR. For UIRs 13-266, 13-270, and 14-010 not all staff identified in the "staff involved" section of the UIR were interviewed therefore these investigations cannot be considered thorough and complete.<br><br>Based on this review this Provision was 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.<br><br>This Provision was not in substantial compliance. | Noncompliance |

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| | (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.<br><br>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.<br><br>For investigations in Sample D.1 and D.2 for which recommendations for programmatic action were made, the following was found:<br>▪ For 12 of 23 (48%), prompt and thorough programmatic action had been taken and documented. Those that did not included DFPS investigations 42898792, 42925051, 42935874, and 42938396; and for Facility investigations UIRs 14-010, 14-018, 14-032, 14-044, 14-048, 14-049, and 14-062.<br>▪ For none (0%), there was sufficient 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 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.<br><br>While the IMC reported his staff kept track of all recommendations and tracked implementation to conclusion, evidence provided to the Monitoring Team did not confirm this. Additionally, 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:<br>▪ 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.<br>▪ 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.<br>▪ 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 | Noncompliance |

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| | | 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.). However, this did not yet provide sufficient information 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 modified.<br><br>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. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| D4 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation. | For all categories of unusual incident categories and investigations, the Facility did have a system that allowed tracking and trending by:<br>▪ Type of incident;<br>▪ Staff alleged to have caused the incident;<br>▪ Individuals directly involved;<br>▪ Location of incident;<br>▪ Date and time of incident;<br>▪ Cause(s) of incident; and<br>▪ Outcome of investigation.<br><br>Over the past two quarters, the Facility's trend analyses:<br>▪ Were conducted at least quarterly;<br>▪ Did address the minimum data elements;<br>▪ Did use appropriate trend analysis procedures;<br>▪ Did provide a narrative description/explanation of the results and conclusions; and<br>▪ Did, as appropriate, contain recommendations for corrective actions.<br><br>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 | Noncompliance |

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| | | were usually developed. This would still be considered a work in progress as the process is still in its early stages.<br><br>As noted in the last report by the Monitoring Team the trend reports and/or minutes did not show that action plans were implemented and tracked to completion. This continued to be the case. 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.<br><br>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. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |

| SECTION E: Quality Assurance | |
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| Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. DSSLC Section E Presentation Book (undated)<br>4. DADS Policy 003.1 - Quality Assurance 1/26/12<br>5. DSSLC Policy CMGMT-15 Quality Assurance 9/1/12<br>6. DSSLC QA Plan 9/24/13<br>7. DSSLC QA Plan Matrix 1/15/14<br>8. Quality Assurance/Quality Improvement Council meeting minutes since the last review<br>9. Facility Trends Monthly Meeting minutes August to December, 2013<br>10. Monitoring tools and guidelines for each provision of the SA (various dates) used by QA department<br>11. Monitoring tools used by departments/disciplines<br>12. Corrective Action Plans (CAPs) initiated since the last review<br>13. CAP tracking logs and related documentation<br>**People Interviewed:**<br>1. Lori Powell, Director of Quality Assurance<br>2. Sarah O'Bryan, Lead Program Compliance Officer<br>**Meetings Attended/Observations:**<br>1. Incident Management Review Team (IMRT) 1/14/14<br>2. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 1/14/14 |
| | **Facility Self-Assessment:**<br>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.<br><br>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.<br><br>For the most part the Facility presented data in a meaningful/useful way. A notable exception was the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by departments and disciplines. 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.<br><br>The Facility rated itself as being in compliance with Provision E.3 of Section E. This was consistent with the |

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| | Monitoring Team's findings.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Some 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. As noted in the last report of the Monitoring Team, 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. In this regard the Facility described three specific steps to address this topic:<br>• Develop a system for Section Leads to receive data from Corrective Action Plans to show progress/regression. If regression, modifications to the Plan will be required.<br>• Develop a system to modify CAPs based upon effectiveness and compliance monitoring.<br>• QA/QI minutes will include effectiveness of the CAPs for the Council to review and approve. |
| | **Summary of Monitor's Assessment:**<br>The Facility had made substantial progress since the last review. QA activities noted in previous reports as "in the early stages of implementation" were becoming more routine. The number of monitoring tools that have inter-rater reliability had increased; however the lack of inter-rater reliability is a primary barrier to compliance. Additionally, the processes for the development of corrective action plans needed improvement.<br><br>The Facility's QA process reviewed by the Monitoring Team demonstrated continued improvement in the organization and collection of data, review and analysis of data, substantive interaction between the QA Department, SA Coordinator and section leads, and presentation and review of data and analysis by the QA/QI Council. Consistent implementation of inter-rater reliability remained a challenge for the Facility.<br><br>There was a complete and adequate data list/inventory at the Facility and the list was current. The Facility's data system had achieved a level of maturity such that multiple variables can be examined for most data points.<br><br>Many key indicators were insufficient to measure improvement or regression in the metric described in the key indicator.<br><br>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.<br><br>The reports prepared by the QA department for the QA/QI Council are extensive and provide much useful |

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| | 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.<br><br>The QA/QI Council reviews each section of the SA at least once a quarter.<br><br>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.<br><br>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.<br><br>Evidence showing how each CAP was evaluated for effectiveness was not apparent to the Monitoring Team. The Facility did not appear to have a systematic or reliable method to determine if a CAP was effective or not.<br><br>With regard to the corrective action planning process the Facility was struggling with developing data-related problem statements from which action steps could be articulated and improvement measured. |

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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><br>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.<br><br>Positive aspects included:<br>• 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.<br>• It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles.<br>• The policy language was simple and straightforward and the bullet style will make it easy for staff to read.<br>• It required disciplines to keep account of their databases and the QA department to keep track of all databases.<br><br>Other comments:<br>• The policy hinted at addressing both systemic issues and serious individual | Noncompliance |

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| | | ones, but stopped short of encouraging the facilities to have procedures to deal with both.<br>• There did not appear to be a list of key indicators or a directive to develop a list.<br>• 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.<br><br>The state policy called for a statewide QA/QI Council and for statewide discipline QA/QI committees. Neither was in place at this time.<br><br>Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this.<br><br><u>Facility QA policies and practices</u><br>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.<br><br>The Facility's QA process reviewed by the Monitoring Team demonstrated continued improvement in the organization and collection of data, review and analysis of data, substantive interaction between the QA Department, SA Coordinator and section leads, and presentation and review of data and analysis by the QA/QI Council. Consistent implementation of inter-rater reliability remained a challenge for the Facility.<br><br>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.<br><br>The QA plan narrative at the Facility had been updated in September, 2013. The plan was comprehensive and addresses:<br>▪ a description of the purpose of the QA program,<br>▪ organizational structure of the QA process (including individual roles and responsibilities),<br>▪ data list/inventory,<br>▪ QA matrix,<br>▪ key indicators,<br>▪ how data are summarized and analyzed,<br>▪ the QA report,<br>▪ QAQI Council and its role in reviewing data and guiding the entire QA process, and<br>▪ corrective action planning and implementation process | |

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| | | 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.<br><br>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), a set of key indicators were included for all 19 sections (100%). Many key indicators were, however, insufficient to measure improvement or regression in the metric described in the key indicator. For instance merely keeping track of the number of restraints in a given month, the number of PICA (or choking) incidents, or the number of infections does not necessarily represent a key indicator without establishing either performance related benchmarks or other measurement criteria . Many key indicators needed refinement as in their present form; many merely establish counts of various events and are not structured in such a manner that would facilitate analysis of improvement or regression in anticipated outcomes affecting Individual health and safety and clinical conditions. Keeping track of counts of various events is an important component of establishing key indicators. Key indicators should also record and report data that can identify trends that may require administrative or clinical response. For example, for restraint, in addition to reviewing the number of restraints, it may be useful to also record the number of individual's restrained, total duration of physical and mechanical restraints, percent of restraints that had associated injuries, restraint associated with newly admitted individuals vs. longer term individuals, For pneumonia, the number of pneumonias, number of individuals who had pneumonia, number of individuals who had multiple pneumonias in a quarter, etc. Key indicators should be sufficiently detailed to enable the Facility to determine if its administrative and clinical systems do, or do not, seem to be improving the health and safety of the Individuals being served by the Facility..<br>Of these 19, both process and outcome indicators were identified for seven (37%). Of these 19, in 19 (100%) where process and/or outcome indicators were present 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 although it did not appear the Facility was using this flexibility in defining and measuring data for most key indicators. .<br>Examples of key indicators used at the Facility for which data was tracked and trended included: number of persons diagnosed with pneumonia, respiratory infections, mobility status, number of restraints, abuse confirmations, timeliness of assessments, percentage compliance scores associated with various monitoring tools (e.g. mealtime audits, positioning audits, and behavioral observations), and hospitalizations. | |

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| | | 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.<br><br>From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that of the 52 items in the QA plan matrix, 46 (89%) 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; data associated with each of these six had been submitted/collected/received by the QA department for the initial quarterly period of implementation.<br><br>Of the 52 items in the QA plan matrix, 46 (89%) 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; data associated with each of these six had been submitted/collected/received by the QA department for the initial quarterly period of implementation. Examples of this include UIR audits, PNMP audits, mealtime monitoring, and treatment sheet audits.<br><br>The QA Plan Matrix included 52 items. The QA Plan Narrative contained 13 components. At the time of the review, of the 65 items/components of the QA plan narrative and QA plan matrix, the Facility implemented 63 (97%). The two components of the QA Plan narrative (2 of 13 = 15%) that were not fully implemented were very important to the successful implementation of the QA system: 1) inter-rater reliability for all monitoring tools, and 2) a systematic corrective action planning process. With regard to inter-rater reliability the Facility reported that 38 of the 52 items in the QA Plan Matrix required inter-rater reliability. At the time of this review inter-rater reliability had been implemented for 13 (34%). With regard to the corrective action planning process the Facility was struggling with developing data-related problem statements from which action steps could be articulated and improvement measured. For example, one CAP when identifying the area requiring a Plan of Improvement (i.e. a CAP) stated "Section R" with no further specification. In reviewing the CAP it was apparent the CAP was intended to address the timeliness of speech assessments. "Improving the timeliness of speech assessments" would have been a more appropriate problem statement that could have included baseline data from which improvement, after implementing CAP action steps, could be measured.<br><br>Documentation and observation indicated that QA staff assisted each discipline in analysis of data. The QA Director and Settlement Agreement Coordinator met monthly | |

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| | | with each SA Section Lead for this purpose.<br><br>Of the 52 self-monitoring tools for the SA, the content of 52 (100%) appeared to be appropriate and the QA Director reported all 52 (100%) were reviewed within the past six months, resulting in revisions to six.<br><br>Of the 52 self-monitoring tools for the SA, 23 (44%) had adequate formal written instructions and guidelines for the user. Most others have at least some instruction included on the self-monitoring tool but in many cases theses instructions are not complete and comprehensive.<br><br>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 52 self-monitoring tools for the 19 sections of the SA (one is not expected for Section E), 13 (34%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-rater reliability). Those that did not primarily lacked sufficient QA department monitoring for inter-rater reliability.<br><br>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-rater reliability) 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.<br><br>Based on this review the Monitoring Team determined this Provision was not in compliance.<br><br>The Facility had made substantial progress since the last review. QA activities noted in previous reports as "in the early stages of implementation" were becoming more routine. The number of monitoring tools that have inter-rater reliability had increased; however the lack of inter-rater reliability is a primary barrier to compliance with this Provision. Additionally, the processes for the development of corrective action plans needs improvement. | |
| 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 | 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.<br><br>Data from the QA plan matrix for 19 of the 19 (100%) sections of the SA (not section E) were, as appropriate, 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 | Noncompliance |

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| | need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur. | the indicator being measured.<br><br>As reported in Provision E.1, the Facility reported that 46 of 52 (89%) 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 permit assessment of trends. Additionally, the lack of inter-rater reliability described in Provision E.1 (25 of 38 monitoring tools lacked inter-rater reliability) and the lack of clear written instructions for monitoring tools described in Provision E.1 (29 of 52 self-monitoring tools did not have clear written instructions) may call into question the integrity of data used in the assessment of trends.<br><br>Since the last onsite review, a meeting occurred between discipline/department staff and QA staff at least once for 19 of the 19 (100%) sections of the SA. These meetings included:<br>o A review of the data listing inventory and matrix,<br>o Discussion of data and apparent outcomes,<br>o A review of the conduct of the self-monitoring tools,<br>o The creation of corrective action plans as appropriate,<br>o A review of previous corrective action plans.<br><br>Since the last onsite review, data were available during these meetings to facilitate department/discipline review and analysis with QA staff; however, as noted in Provision E the Facility reported that 46 of 52 (89%) of the monitoring tools used by the Facility had been in 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.<br><br>The Facility reported in its Self-Assessment that since the last review 15 CAPs had been initiated; however, (as noted in the last report by the Monitoring Team) the origin of each CAP was not clear. It could not be determined from reviewing CAPs 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.<br><br>Since the last onsite review, a facility QA report (for presentation to the QA/QI Council) was created for each month. The reports prepared by the QA department for the QA/QI Council were 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 | |

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| | | 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.<br><br>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.<br><br>Of the sections of the SA that were presented, 20 of 20 (100%) contained the following components:<br>• Self-monitoring data (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate)<br>• Key indicators (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate).<br>• Narrative analysis<br><br>Some of the above data may be of limited utility because of the lack of properly defined key indicators, the lack of inter-rater reliability for each section of the SA, the lack of clear instructions for the use of monitoring tools, and in some cases the lack of longitudinal data described above.<br><br>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.<br><br>Since the last onsite review, the QA/QI Council met at least once each month. In fact, the Facility sometimes 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:<br>1. Accomplishments for the last three months.<br>2. Upcoming challenges and plans for overcoming these challenges.<br>3. Data analysis<br>4. Review of Corrective Action Plan(s)<br>5. Status of policy/procedure review, revisions, and implementation<br>6. Summary of any relevant committee recommendations<br>7. Priorities for the next quarter<br><br>Agendas were structured so that each Section of the SA was reviewed at least once every three months.<br><br>The second QA/QI Council meeting of the month was referred to as the "business | |

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| | | 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 and personnel management issues.<br><br>Minutes from eight of eight (100%) QA/QI Council meetings since the last review indicated that the meeting occurred according to schedule.<br><br>Minutes from eight of eight (100%) QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics,<br><br>Minutes from eight of eight (100%) QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments.<br><br>Minutes from five of eight (63%) 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, ar analysis of data were presented. This was appropriate; as reported earlier; the other three QA/QI Council meetings served a different purpose As noted above, some of the above data may be of limited utility because of the lack of properly defined key indicators, the lack of inter-rater reliability for each section of the SA, the lack of clear instructions for the use of monitoring tools, and in some cases the lack of longitudinal data as described above.<br><br>In five of eight (63%), recommendations and action plans were developed. These were selected when appropriate to do so, and were based on the data presented. This was appropriate; as reported earlier, the other three QA/QI Council meetings served a different purpose.<br><br>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.<br><br>The Facility processes for initiating, implementing, and tracking CAPs had become more organized than that observed the last review. As described in above and in Provisions E.3 and E.4, there are still many improvements needed in CAP development, implementation, outcome monitoring, and related administrative systems.<br><br>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 | |

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| | | monitoring data showed performance indicators were not at, or had dropped below, a pre-determined threshold (for example, 85%). As the QA system evolves and matures and the number of CAPs increases over time 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.<br><br>When considering the full set of CAPs, they did appear to have been chosen following the written description policy or procedure.<br><br>Of the 15 CAPs reviewed by the Monitoring Team, 15 (100%) appeared to appropriately address the problem for which they were created. This could be determined through a review of the entire CAP and generally related to the outcomes associated with the use of monitoring tools. As noted in Provision E.1 nearly all CAPs were deficient in identifying the specific problem being addressed by the CAP and articulating it in the section of the CAP labeled "Area requiring POI" or "Issue Requiring Corrective Action."<br><br>Based on a sample of 15 CAPs:<br>• 15 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence.<br>• None (0%) included the anticipated outcome of each action step.<br>• 15 (100%) included the person(s) responsible.<br>• 15 (100%) included the time frame in which each action step must occur.<br><br>Based on this review this Provision was 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, clear instructions for the use of monitoring tools, and longitudinal data for all elements of the QA Plan Matrix)) had not as yet been achieved. | |
| E3 | Disseminate corrective action plans to all entities responsible for their implementation. | Based on a sample of 15 CAPs:<br>• 15 (100%) that included documentation about how the CAP was disseminated.<br>• 15 (100%) that included documentation of when each CAP was disseminated.<br>• 15 (100%) that included documentation of to whom it was disseminated, including specific person(s) responsible.<br><br>These data were recorded on each CAP and included target dates for CAP completion. Additionally a review of CAP status was included in SA Section presentations at QAQI Council meetings. | Substantial Compliance |

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| | | Based on this review this Provision was in substantial compliance. | |
| E4 | Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified. | 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.<br><br>The Facility reported in its Self-Assessment that it had not as yet developed a process to determine (and document) whether or not a CAP had been implemented fully and in a timely manner. Through interview and document review this was confirmed by the Monitoring Team.<br><br>Based on this review this Provision is not in compliance. | Noncompliance |
| E5 | Modify corrective action plans, as necessary, to ensure their effectiveness. | The Facility did not appear to have a systematic or reliable method to determine if a CAP was effective or not. Evidence showing how each CAP was evaluated for effectiveness was not apparent to the Monitoring Team. Completed CAPs had a handwritten marginal note indicating the CAP was effective but no information (i.e. data) which could explain how such a determination was made. Additionally, these marginal notes were not initialed or signed so it could not be determined who made the judgment that the CAP was effective.<br><br>Deficient practices in regard to Provision E.5 were apparent to the Facility as in its Action Plan (which accompanied the Self-Assessment) it described three specific steps to address this topic:<br>• Develop a system for Section Leads to receive data from Corrective Action Plans to show progress/regression. If regression, modifications to the Plan will be required.<br>• Develop system to modify CAPs based upon effectiveness and compliance monitoring.<br>• QA/QI minutes will include effectiveness of the CAPs for the Council to review and approve.<br><br>The Monitoring Team looks forward to reviewing these improvements at the next review.<br><br>Based on this review this Provision was not in compliance. | Noncompliance |
| **SECTION F: Integrated** | | | |

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| **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:**<br>**Documents Reviewed:**<br>1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 12/27/2013<br>2. Denton State Supported Living Center Action Plans, Compliance Visit Round 7, January 13-17, 2014<br>3. Denton State Supported Living Center Report for Monitors<br>4. Section F Presentation Book materials<br>5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10<br>6. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013<br>7. Summary of Changes to DADS Policy 004.2: Individual Support Plan Process<br>8. Draft DADS Policy 017: Habilitation, Training, Education and Skill Acquisition Programs, effective 5/10/12<br>9. DSSLC Policy CMGT 12: Personal Support planning Process (Integrated Protections, Services, Treatments and Supports, dated 08/05/11<br>10. 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<br>11. DSSLC Policy CMGMT 03: Integration Of Clinical Services, dated December 1, 2013<br>12. Plan to Support People to Live in the Most Integrated Setting of Their Choice, undated<br>13. QIDP Roster, dated December 2, 2013<br>14. Current/Prior PSP Dates, dated Wednesday, December 04, 2013<br>15. ISP assessments for Individuals #4, #26, #177, #221, #311, #376, #408, #565, #608 and #564<br>16. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #4, #26, #177, #221, #228 ,#311, #376, #408, #565, #608, #564 and #567<br>17. Monthly and Quarterly Reviews for Individuals #4, #26, #177, #182, #221, #228, #311, #376, #408, #565, #608, #564, #567, and #791<br>18. ISPs, ISP assessments, and Monthly Reviews for Individuals #228, #567 and #791<br>19. Individual Support Plans (ISPs), ISP assessments, Monthly Reviews and Skill Acquisition Plans (SAPs) for newly admitted individuals: Individuals #251, #280, #459, #666 and #800<br>20. Section F materials from the QA/QI Report, dated November 19, 2013<br>**People Interviewed:**<br>1. Clark Clermont, Director of Community and Family Relations (CFR)<br>2. Leslie Clark, Qualified Intellectual Disabilities Professional (QIDP) Coordinator<br>3. Julie Kuester, QIDP Educator<br>4. Lori Powell, Director of Quality Assurance<br>5. Dora Tillis, Assistant Director of Programs<br>**Meeting Attended/Observations:**<br>1. Annual ISP meetings for Individuals #228, #567 and #791<br>2. ISP Preparation meeting for Individual #182 | |
| | | **Facility Self-Assessment: Facility Self-Assessment:** | |

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| | | 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.<br><br>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 on data from a sample of ten Integrated ISP Monitoring Tools, as completed by the Section F staff, but did not reference data collected through the Facility's QA/QI processes or that subsequent analysis. This was problematic, as there were significant differences between the two. Section F self-assessment data were far more positive than the current QA/QI findings, and the latter appeared to be considerably more reflective of the reality based on the Monitoring Team's review. For purposes of objectivity and long-term sustainability, the Facility should ensure that its QA/QI data and analysis are foundational to the self-assessment process.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance, including training, monitoring and assuring adherence to current policies. Once it develops provision-specific outcome indicators, as recommended above, the Facility should review these Action Steps to ensure they are focusing on those most likely to support the identified outcomes. Some of the Action Steps appeared to be relevant to achieving compliance, but it was not always clear how each of the actions would support that end. 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. Sections of the Self-Assessment did on occasion reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which can tie the Self-Assessment and Action Plans together. 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. This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data.<br><br>The Facility indicated that its Self- Assessment resulted in findings of noncompliance in all sub-provisions of Section F, and the Monitoring Team concurred with the overall assessment of noncompliance. It did not always concur with the analysis and/or rationale the Facility used to justify the self-ratings, as these were often too narrowly conceptualized and did not take into account each and every factor the Monitoring Team has raised as the reasons for noncompliance. This may lead to a false expectation that achieving one of several requirements will be sufficient to obtain substantial compliance. The Monitoring Team urges the Facility to address the entire scope of the noncompliant factors, in a sort of master plan, even if it finds it necessary to prioritize the order in which it plans to address them. | |

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| | | **Summary of Monitor's Assessment:**<br>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 had recently embarked on an extensive training effort for QIDPs on the ISP process, facilitation and person-centered planning, and the QIDP Educator was in the process of becoming certified in Person-Centered Thinking. On a very positive note, the Monitoring Team was able to observe continued progress in the participation of direct support professional (DSP) in the on-site meetings that contributed tremendous value to the interdisciplinary process. The Facility was to be commended for this effort. The Facility was to also to be commended for its continuing efforts toward developing a comprehensive quality assurance system for this Section.<br><br>**Provision F1:** This provision was not in compliance**.** A revised DADS Policy 004.2: Individual Support Plan Process had been issued in November 2013, but few significant changes had been made. The revised ISP format and process was still in use and considerable training and coaching continued to be provided to the QIDPs and IDTs. IDT participation, especially for DSPs, continued to show improvement. 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. Facilitation continued to provide mixed results. The Monitoring Team was particularly concerned with the Facility's development of the ISP in accordance with the Americans with Disabilities Act (ADA) and Olmstead decision.<br><br>**Provision F2:** This provision was not in compliance**.** ISPs reviewed still lacked many of the criteria specified in the SA for this Provision. 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 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 a meaningful or purposeful manner, although some progress was noted. As described 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. | |

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| **F1** | **Interdisciplinary Teams -**<br>Commencing within six months of the Effective Date hereof and with full implementation within two | | |

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| | 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) was the one person assigned to each individual to facilitate the work of each IDT.<br><br><u>Staffing of QDDP Department</u><br>The Facility reported that it had 30 QIDP positions, including four Lead QIDPs. There were also a QIDP Coordinator, a Facilitator Coordinator and a QIDP Educator. All individuals had an assigned QIDP. The QIDP/individual ratio was not specified in the QIDP Roster, dated December 2, 2013 provided for review, but it appeared to be sufficient based on the ratio of staff to individuals residing at the Facility. With 469 as the current census, an average caseload would be approximately 15 for each QIDP.<br><br><u>Process of determining competency of QIDPs in the facilitation process</u><br>Based on the list provided, six of the 30 QIDPs (20%), the QIDP Coordinator and the Facilitator Coordinator had been deemed fully competent in facilitation. During interview, the Section F lead indicated this figure stood at seven. The Facility was using the Q Construction Facilitation curriculum for training in this area and evaluating competence. It had also devoted considerable resources to developing and implementing training for QIDP 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 participation of the IDT members at the meetings.<br><br>This represented progress over the previous site visit; however, outcomes in terms of improvements in ISPs were not yet substantial. For example:<br>• For none of the ten 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.<br>• For none of the ten ISPs reviewed (0%) did the facilitation process result in an adequate discussion of the most integrated setting.<br>• For one of three ISPs annual meetings observed (33%) the facilitation process resulted in the adequate participation of the individual, although some progress was noted in a second ISP as well. See Provision F1b.<br><br>The assigned QIDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found in its review of the sample of ten ISPs the QIDPs 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. | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Conclusion: This provision was found to be not in compliance.</td><td></td></tr>
<tr><td>F1b</td><td>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.</td><td><u>Composition and Participation of IDT:</u><br>A recently issued revision to the Individual Support Plan Process policy, DADS Policy 004.2 dated 11/21/2013, clearly identified requirements for interdisciplinary team (IDT) composition, attendance, and participation, and the processes for ensuring them. For purposes of this provision, the changes were minimal from the previous version. During the ISP Preparation meeting, the policy still called for the IDT to identify the requisite composition of the team for the purposes of the annual planning meeting and record this in the Attendance-Assessment checklist.<br><br>The Facility provided a document entitled ISP Meeting Attendance 8/1/13-11/30/13 that provided ISP attendance data for various IDT members, as follows:<br><br>
<table>
<tr><th>Discipline</th><th>Count of Attendance</th><th>Total Required</th><th>Percent Attendance</th></tr>
<tr><td>Admission/Placement Coordinator</td><td>7</td><td>168</td><td>4%</td></tr>
<tr><td>Contract LA</td><td>106</td><td>168</td><td>63%</td></tr>
<tr><td>Designated LA</td><td>23</td><td>168</td><td>14%</td></tr>
<tr><td>Dietician/Nutritionist</td><td>44</td><td>44</td><td>100%</td></tr>
<tr><td>Education and Training/Day Programming</td><td>131</td><td>168</td><td>78%</td></tr>
<tr><td>Home Staff</td><td>167</td><td>168</td><td>99%</td></tr>
<tr><td>Individual</td><td>147</td><td>168</td><td>88%</td></tr>
<tr><td>LAR</td><td>103</td><td>107</td><td>96%</td></tr>
<tr><td>Nurse</td><td>163</td><td>168</td><td>97%</td></tr>
<tr><td>OT/PT</td><td>168</td><td>168</td><td>100%</td></tr>
<tr><td>Other</td><td>110</td><td>168</td><td>65%</td></tr>
<tr><td>Other: HRO</td><td>1</td><td>168</td><td>1%</td></tr>
<tr><td>Physician/PCP</td><td>153</td><td>168</td><td>91%</td></tr>
<tr><td>PNMP Coordinator</td><td>1</td><td>168</td><td>1%</td></tr>
<tr><td>Psychiatrist</td><td>81</td><td>83</td><td>98%</td></tr>
<tr><td>Psychology/Behavior Analyst</td><td>87</td><td>87</td><td>100%</td></tr>
<tr><td>QIDP</td><td>163</td><td>168</td><td>97%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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| Speech/Communication Therapist | 85 | 111 | 77% |
| Vocational Services | 52 | 168 | 31% |

The Monitoring Team also reviewed the ISP Preparation documentation and signature sheets for four 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 appeared to be fairly consistent with the Facility's data.

- Three of four (75%) included the individual;
- Three of four (75%) included a Direct Support Professional;
- Four of four (100%)included the QIDP;
- Two of three (67%) included a family member/LAR or advocate;
- Four of four(100%)included the Registered Nurse;
- Three of four (75%) included Psychologist or Behavior Analyst (BA);
- One of one (100%) included Active Treatment staff;
- Four of four (100%)included the Primary Care Physician;
- Three of three (100%)included a representative from OT/PT; and,
- Three of three (100%)included a Speech Therapist

The Monitoring Team evaluated participation at the ISP Preparation meeting as well. For the 29 meetings held during month of January, 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 to a high of six. For 14 of the 29 meetings (48%), only three staff attended. Only one of 29 meetings (3%) was attended by the individual; while individuals' attendance was not required by policy, many significant issues important to and for the person were discussed at these meetings.

The Monitoring Team also observed that signature sheets sometimes failed to convey the actual participation of IDT members. For the ISP annual planning meeting for Individual #228, two Speech Language Pathologists (SLPs) and a Behavioral Health Specialist (BHS) were both in attendance, but for only portions of the meeting. The SLPs arrived late and left after a discussion of the individual's dysphagia and potential for return to some level of oral eating. The BHS left prior to the discussion of behavioral health. As a result, the IDT did not have the opportunity to have a full discussion of the individual's communication and behavioral needs, which were complex. The Psychiatrist, who did remain for the entire meeting, noted the absence of the BHS and said that he would not be able to speak much to the behavior support plan. He indicated only that he didn't think they had discussed making any changes to the plan. It is critical that the entire IDT participate in discussions and decisions regarding the behavior plan; the failure of the

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| | | SLP and BHSs to participate deprived the IDT and the individual of a meaningful discussion of the needs and plans.<br><br>On a very positive note, however, the Monitoring Team was able to observe continued progress in the participation of DSPs in the on-site meetings. For the ISP annual planning meeting for Individual #567, in particular, the Monitoring Team was extremely impressed with a DSP in attendance during the second half of the meeting. She was very knowledgeable about the individual, offered insights and suggestions and contributed tremendous value to the interdisciplinary process. Both she and the Facility are to be commended for this effort.<br><br><u>Extent of Individual participation in ISP:</u><br>Despite some improvement in actual meeting participation by individuals as noted in Provision F1a above, meaningful participation remained very limited, as reported in previous assessments by the Monitoring Team.<br><br>The Director of CFR reported at the time of the last monitoring visit 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:<br>1) Each individual will have an ISP preparation meeting {ISP Prep) three months before the scheduled ISP meeting.<br>2) Prior to the ISP Prep meeting a Preferences & Strengths Inventory (PSI) will be conducted with the individual.<br>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."·<br>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.<br>5) 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.<br>6) At the ISP meeting the individual will be encouraged to inform the ISP members of their vision for their future; their thoughts, desires, wants, | |

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| | | needs and goals they may have.<br><br>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 QIDPs had received training related to this process. The Monitoring Team commended this overall initiative and believed it held promise toward achieving compliance with this provision and, more importantly, for supporting individuals to participate fully in planning for their own futures. The Monitoring Team looked forward to the opportunity to review the outcomes of this initiative, but found it had been minimally implemented in the past six months. It was reported that perhaps five or six individuals had had assistance from Life Skills to promote participation thus far.<br><br>For two of three (67%) ISP annual meetings observed during this monitoring visit, there was some progress noted with the IDT involving the individual. The IDT involved Individual #791 throughout the discussion. For Individual #228, there was also some progress noted, but improvement was still needed. Individual #228 would have greatly benefited from preparation to support participation in the meeting. His comprehension of the proceedings was good and he had clear preferences, but his speech was often difficult to understand. It would have been valuable for his QIDP or the facilitator to meet with him beforehand to discuss the decisions that were going to be made, to ensure his input was received and understood. This was particularly true as it related to the living options discussion, as further detailed in Provision F1e, but would have been helpful in most of the meeting.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | |
| F1c | Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs. | <u>Extent to which assessments are conducted routinely:</u><br><u>Policy:</u><br>DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP."<br><br>For annual ISP planning meetings, the expectations remained that 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. The IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting, also held approximately 90 days prior to the ISP meeting. The policy requires in Section III.C that these assessments be | Noncompliance |

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completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting to permit the entire interdisciplinary team (IDT) to review them. The assessments were to be used by the QIDP to develop an ISP Guide no later than five days prior to the ISP annual meeting. For a new admission, Facility policy requires that the assessments be completed and posted at least five working days prior to the initial ISP planning meeting, with the exception of the PSI, which was to be completed ten days prior. There was evidence the IDTs had begun making use of these processes to ensure needed assessments were completed on a timely basis to an extent, as five of ten (50%) recent ISP Preparation documents clearly defined the assessments that were to be completed. It remained concerning, however, that the Facility was not able to produce evidence this was accomplished for the remaining 50%.

Assessments for the ISP were also still not routinely completed on a timely basis, but there was improvement noted. The Facility reported that progress was being made over previous site visits and provided the following data, by discipline, represented in the table below:

| | August 2013 | Sept 2013 | Nov 2013 | Dec 2013 |
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| Life Skills | 85% | 100% | 93% | 98% |
| Audiology | 96% | 100% | 93% | 96% |
| OT/PT | 89% | 81% | 91% | 88% |
| Vocational | 96% | 94% | 100% | 97% |
| Self Administration of Medication | 76% | 79% | 81% | 72% |
| Speech | 100% | 97% | 95% | 96% |
| Dental | 94% | 92% | 87% | 84% |
| Pharmacy | 100% | 100% | 100% | 100% |
| Psych | 74% | 75% | 85% | 74% |
| Medical | 75% | 88% | 76% | 75% |
| FSA | 64% | 90% | 77% | 58% |
| Nursing | 71% | 81% | 77% | 58% |
| Totals | 85% | 90% | 88% | 84% |

The Monitoring Team reviewed the timeliness of assessments overall for a sample of ten completed ISPs as well as for an upcoming ISP as a comparison. While assessment of timeliness remained a concern, there was evidence that the Facility was achieving some progress in this area. Findings included:

- In the sample of ten ISPs completed prior to the monitoring visit, none (0%) had all required assessments included and completed on a timely basis, at least ten

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| | | working days prior to the ISP annual meeting. In several instances, some assessments were still not completed until after the meeting was held.<br>• Overall for this sample, however, the rate of timeliness was 73%, which indicated significant progress from the finding of 52% at the time of the previous monitoring visit. It was generally not possible to ascertain assessments that might be missing altogether, as only 50% 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.<br>• As reported in Provision V4, the Monitoring Team also viewed the assessments available on the shared drive for Individual #299, who had an annual ISP meeting scheduled within the next ten working days. For 19 assessments that were required per the ISP Preparation meeting, 12 (63%) were available<br><br><u>Extent 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><br>DSSLC had taken several steps to improve the quality of its assessments such that they would more likely reliably identify the individual's strengths, preferences and needs. These included:<br>• Effective October 1, 2013, the Facility had begun using statewide standardized assessment templates, with the exception of the Rights Assessment, Structural & Functional Assessment, and Pharmacy. These were intended to ensure all assessments would have a consistent foundation of information and analysis to be included. These templates were reviewed by the Monitoring Team. Each included specific sections, including the following:<br>I. History<br>II. Current Status (Diagnosis, Active Problem List, Risk Levels)<br>III. Current Services (Medications, Treatments, Training, Supports)<br>IV. Preferences, Strengths, Goals (from ISP Preparation meeting)<br>V. Evaluation/Assessment Results<br>VI. Additional Strengths, Contraindications to Stated Goals<br>VII. Community Living/Services<br>VIII. Summary<br>IX. Recommendations<br>The Monitoring Team found it was positive that DADS had established certain expectations. For the most part, however, the significant concerns the Monitoring Team had about the quality of assessments in the past had less to do with the format and more to do with the rigor of the assessment process. The Facility should guard against any tendency toward a fill-in-the-blanks approach | |

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| | | to assessment as it moves forward with implementation of these new templates.<br>• QIDP staff were now completing the PSI process, as described in DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013. The QIDPs were more familiar with specific individuals than the QA Auditor who had previously been assigned to complete the PSIs for all individuals living at the Facility. This was expected to result in PSIs that reflected this familiarity.<br>• The Facility continued to implement an "assessment of assessments" for some disciplines, including Medical, Pharmacy, Vocational, OT/PT and Speech. This was a quality assurance process implemented by each of those departments in which some sample of assessments was reviewed by departmental managers or, as in the case of the physicians, an external reviewer.<br>• The Facility reported it had just recently begun to hold an IDT meeting prior to the ISP to review assessments and identify/resolve any discrepancies. The Monitoring Team commends this step. To move in the direction of substantial compliance, the Monitoring Team recommends the QIDPs receive training in how to complete a record review for the purposes of identifying needs, concerns, gaps and discrepancies, and that such a review be an expectation prior to the ISP Preparation meeting and the annual ISP planning meeting.<br><br>Progress was noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included:<br>• As reported in Provision M2, three of three (100%) Annual Comprehensive Nursing Assessments were completed timely, within 10 days of the ISP meetings and four of four (100%) New Admission Nursing Assessments were completed timely, within 30 days of admission.<br>• As reported in Section P, Provision P1, related to comprehensive Occupational Therapy (OT) and Physical Therapy (PT) screening and comprehensive assessments was found to be in substantial compliance.<br><br>Despite some progress 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, K6, L1, M2, O2, O8, 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.<br><br>The Monitoring Team also reviewed the assessments used in the ISP annual meetings held during the on-site visit for Individuals #228 and #567and found the following discrepancies and concerns across a number of disciplines regarding their sufficiency to reliably identify the individual's strengths, preferences and needs. There was particular concern about health and medical needs of these individuals. These were shared with the | |

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| | | Facility at the conclusion of the meetings. For example:<br>• Individual #228 was known to have significant medical issues but there were also conditions identified by other medical consultants, and diagnostic tests, that were not listed on the annual medical assessment, or active problem list. Blood counts indicate a diagnosis of anemia; however, a diagnosis of anemia was not noted on the annual medical assessment or acute problem list, and was not discussed at the ISP meeting. The Individual had had two colonoscopies. The first colonoscopy reported adenomatous polyp, and a follow-up colonoscopy in 2012 reported that a polypectomy was completed; however, the annual medical assessment, and the IRRF document indicated that the pathology report was not reviewed, and the Facility was not aware of the results. Also noted on the colonoscopy report was the finding of diverticulosis, and diverticulosis was not indicated as a diagnosis on the annual medical assessment or active problem list. See Provision L1 for additional details.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. Assessments were not completed routinely in a timely manner nor were they consistently 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><br>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 QIDPs to complete the ISP Guide five days before the ISP annual planning 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 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:<br>• As reported in Provision U1, the Facility did not routinely use standardized or valid instruments, methodologies and/or processes to assess functional decisional capacity.<br>• As reported in Provision T1e, assessments prepared for individuals with Community Living Discharge Plans (CLDPs) in the past six months did not adequately address significant issues that could impact a safe transition to community living.<br>• As reported in Provision S1, there was little to indicate that the Facility systematically and comprehensively integrated assessments into the | Noncompliance |

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| | | development of Skill Acquisition Programs. In 64% of the reviewed SAPs it was not evident that the Functional Skills Assessment (FSA) had been effectively used in the development of skill acquisition programs. In none of the 14 records (0%) was there indication that the formal assessment of adaptive skills was used in formulating teaching programs.<br>• As further described in Provision F2a1, preferences and strengths identified in the PSI were not effectively incorporated into the ISP and Action Plans.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | |
| F1e | Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). | <u>Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision</u><br>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 there was progress evidenced in the presence of the required determination, but it was still not being consistently provided.<br>• Of the ten ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. Of the 98 total assessments that were reviewed, 55 (56%) included a determination of whether the individual could be served in a more integrated setting.<br>• Of the 98 total assessments reviewed, two (4%) included substantive recommendations for how the individual's needs could be met in a more integrated setting. It was noted that many of those statements were considered non-substantive despite the fact that many of them appeared to be lengthy. Careful analysis of the statements frequently revealed that much of the information provided was not discipline specific and often included generalities related to service providers and services that would be required of anyone living in the community, not an individual with specific needs and supports. Specifically, many included statements such as, "the individual could be served in the community if he/she had access to a physician, dentist, audiologist, speech therapist, physical therapist, nurse, etc., a private space, and a yard with a fence." Such statements failed to cite specific services and supports that were identified within the assessment that would need to be provided to the individual living in the community. Such statements should be discipline specific and provide a professional opinion on what services and supports the individual would require in a community setting, and should include a rationale, based on identified needs, for the provision of such services and supports.<br>• Ten of ten ISPs (100%) included an independent recommendation from the | Noncompliance |

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| | | professionals on the team to the individual and LAR. Of the ten ISPs, however, only one (10%), for Individual #221, provided a discussion of the protections, services and supports that would be needed by the individual in the most integrated setting that could be deemed reasonably adequate.<br>• 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.<br>• In some 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 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. See Provision T1b1 for examples.<br><br>In the section below that addresses Provision T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example:<br>• None of nine (0%) of the completed ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles.<br>• In none of nine (0%) that identified LAR or individual choice as a barrier were there sufficient action plans developed to address these specific barriers. Most were limited to providing annual CLOIP information and/or Provider Fair invitations.<br><br>As it relates to this provision, there was little overall progress demonstrated in the ability of the IDTs to identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. This may be attributed in part to a sequence that did not ask the team to actually determine the most integrated appropriate setting until after the individual's services and supports had been identified. This tended | |

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| | | to perpetuate the tendency of the teams to focus primarily on the supports and services currently being provided at the Facility. While such an array may include many essential services and supports, it does not take into adequate consideration the varied needs that may be needed for successful transition and community living. The IDT must identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles to movement. The Monitoring Team was concerned that the new standardized assessment templates did not always clearly require the IDT members to provide an affirmative description of the individualized needs in a community living setting.<br><br>If the IDT members have reached a general consensus that the individual could be served in a community setting, it is incumbent upon them under the SA and Olmstead to address what would be needed to facilitate that, regardless of whether a referral is made. If the team does not address these needs because a referral is not made, this results in little likelihood of a referral being made. Engaging the IDT, including the individual and family/LAR in a discussion of both obstacles and opportunities is an essential component of an ISP developed in accordance with the ADA and Olmstead.<br><br>Three ISP annual planning meetings were attended during the on-site visit and there was discussion of community living options observed in each (100%). The Monitoring Team was very concerned about the IDT's treatment of the living options discussion in one of these meetings, however. For Individual #228, the IDT asked the individual on several occasions and in several different ways if he was interested in moving to the community and he answered in the affirmative on each occasion. The question was posed, for example, as to whether the individual would like to look elsewhere in the city, whether the individual wanted to move and whether the individual liked community living options. The individual indicated yes to each. The IDT did not respond appropriately to his indications of interest, reminding him repeatedly that he had said many times before that he was not interested. The ISP narrative indicated he appeared to be confused, but the Monitoring Team did not observe any confusion on the individual's part during this exchange. Even if confusion existed, it should not have obviated the repeated affirmative statements; they deserved consideration.<br><br>While it may have been the case that this was the first time he expressed an interest, the IDT should have undertaken serious discussion based on his current answer. | |

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| | | Instead, this was not only ignored but not addressed with any meaningful Action Plan for further exploration. The final determination by the facility discipline members was that the individual could be served in a less restrictive setting at this time, but that the individual should continue to reside at the Denton SSLC. This determination was reported to be based on the discussion during the ISP annual planning meeting. The IDT further stated the individual had no clear understanding of the options available for alternative community placement although the information has been presented and that he appeared to be confused. The IDT agreed if the individual expressed a wish to tour community homes and potentially community placement, a plan would be developed to help with achieving this goal. It went on to say that at this time, a referral is not being opened and the information will be presented to the individual and brother prior to the next ISP meeting. In addition the individual would be offered opportunities to attend provider fairs every six months.<br><br>ISP Service objectives were developed for attendance at semiannual provider fairs and opportunities to take tours of community living options if the individual expressed an interest. It was clear the individual was expressing an interest at the ISP annual planning meeting, but was told by trusted, familiar staff that this was not what he really meant. This was a disservice to the individual. While he may have ultimately decided he was not interested in community living, a more appropriate Action Plan for community exploration would have ensured this decision was an informed one.<br><br>It was also noted the ISP did provide substantial detail about supports and services the IDT believed would be necessary for Individual #228 for a successful community transition, but these were not actually discussed by the IDT at the annual ISP planning meeting.<br><br><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:<br>• 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 | |

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| | | take final precedence.<br>• 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. | |
| **F2** | **Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below: | | |
| F2a | Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that: | | |
| | 1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation; | This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below.<br><br><u>Identification and Use of Individuals' Preferences and Strengths:</u><br>In the review of ten ISPs, the Monitoring Team found there was some progress in the efforts by IDTs to incorporate individuals' preferences into action plans. Preferences and strengths identified in the PSI were acknowledged at the beginning of the ISP Preparation meetings and ISPs and the Monitoring Team did observe some Action Plans and Service Objectives related to preferences. These still tended to be formulated in a generic manner, i.e. will go on community outings "consistent with preferences." Overall, however, none of ten (0%) ISPs had effectively identified and incorporated preferences.<br><br>Preferences continued to be focused on favorite foods and environmental likes and dislikes. The IDTs should expand their approach to include an examination of where and how an individual would like to live, what kind of work and/or avocation is meaningful to the individual, preferences related to social interactions beyond the basics of enjoying staff interaction and/or personal space, and how individuals relax and/or spend spare time. If these preferences are not known or cannot be discerned, this should indicate to the IDTs a need to implement Action Plans to help the person discover them. In another note, the IDTs should avoid listing as preferences such behaviors as packing items in | Noncompliance |

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| | | mouth and self-stimulatory activities to include finger flicking. While individuals may engage in these activities, the goal is to identify preferences that can be functionally incorporated into a personally meaningful day and that do not also encourage harmful or stigmatizing behaviors.<br><br>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. The Monitoring Team observed that IDTs may want to consider some additional approaches to identifying strengths as this appeared to be more difficult for them than identification of preferences. Questions they may want to ask could include:<br>• What is the individual good at?<br>• What do people like about the individual?<br>• What is your favorite thing about the individual?<br>• What can/does the individual contribute to friends, family, community?<br>• What special talents does the individual have?<br><br><u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed:</u><br>The Monitoring Team found that none of the ten 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 and provided an appropriate justification. For Individual #565, the ISP did document a prioritization decision, but it did not appear to be a well-justified one. The ISP listing of preferences and strengths was minimal, but did include attention from staff, including conversation and holding hands as an important personal preference. It was also documented the individual had limited family contact and no discernible relationship with housemates. The IDT then determined there would not be a goal specifically related to relationships, but would instead focus efforts on leisure interests. No justification was given for the decision to make this prioritization. Given the overall assessment that meaningful relationships was an area of significant deficit, the IDT could have developed a plan that specifically integrated relationship development and leisure activities, rather than having to decide between one or the other.<br><br>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 nine (0%) recent ISPs reviewed in which a referral was not made evidenced proficiency | |

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| | | in this regard. Also see Provision F1e above.<br><br>Identification of Supports Needed to Encourage Community Integration:<br>There was some progress noted in identification of supports for community integration, in that seven of ten (70%) ISPs reviewed included Action Plans for specific SAPs for which the community was identified as one of the options for implementation. It was noted, however, that none (0%) of the Action Plans actually indicated any requirement for a minimum frequency of implementation in the community.<br><br>Overall, IDTs did not yet consistently encourage community participation. Action Plans that addressed community participation were still frequently general in nature and referred to the individual having opportunities for community outings and sometimes calling for the outings to be consistent with individual's preferences. For three of ten (30%) ISPs, the ISPs did provide at least one specific destination for a community activity, but none of ten (0%) described any activity that would promote the actual integration of the individual with others living in the community. See also Provision F2a4 below.<br><br>As reported in Provision S3b, documentation provided during the current site visit reflected an increasing trend in the number of community outings that included SAP implementation. 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.<br><br>To move in the direction of substantial compliance, and as recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual.<br><br>Conclusion: This provision was found to be not in compliance. | |
| | 2. Specifies individualized, observable and/or measurable goals/objectives, the | 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:<br>For none of ten (0%)recent ISPs reviewed, did the IDTs consistently develop a | Noncompliance |

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| | treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs; | 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. As described in Provision F2a4 and further 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. On a positive note, however, in seven of the 12 (58%) areas included in a review of SAP methodology, there was improvement of at least five percent. Not all of these areas of improvement reflected ratings that approached the criteria necessary for substantial compliance. Nevertheless, these ratings suggested a meaningful effort on the part of the Facility to improve skill acquisition programs.<br><br><u>Adequacy of processes for identification of and plans to overcome barriers to living in the most integrated setting:</u><br>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 developing ISP Action Plans to overcome such barriers. 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 ten (0%) recent ISPs reviewed evidenced proficiency in this regard. Also see Provision F1e above.<br><br>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><br>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. Adequate integration can be demonstrated through:<br>• 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; | Noncompliance |

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| | | • Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans;<br>• Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.)<br>• Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary<br><br>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.<br><br>There was some progress noted. For example:<br>• As reported for Provision P2, sixteen of 16 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.<br><br>The Monitoring Team found that, although teams were making progress in their efforts to identify and incorporate individuals' preferences and work in a more integrated manner, none of ten 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. The IDTs observed during this monitoring period appeared to be making some progress in this regard, but were not consistently able to conceptualize how an individual's preferences, strengths, behavioral health needs and skill development could be integrated and woven throughout the day.<br><br>For example, an ISP Preparation Meeting was held for Individual #182. There was concern expressed that the individual, who was self-described as "retired," did not want to attend programming, but preferred to go to different areas of the campus looking for coffee. In fact, much of the individual's activity was motivated by coffee consumption, with the IDT members noting that most events were of no interest if coffee was not involved. The IDT expressed concern that moving about the campus looking for coffee | |

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| | | was sometimes accompanied by digging through dumpsters. Additional concerns expressed were that the individual tended to self-isolate and didn't like to participate in large group activities, even though there was some sociability on the individual's own terms; that the individual needed to avoid concentrated sweets and develop an understanding of the need for a prescribed meal texture; and, that toileting independence needed to be better supported through adherence to a toileting schedule. The IDT developed singular plans to address each of these. Following the meeting, the Monitoring Team suggested the IDT consider a more holistic and integrated approach that could incorporate all of these. For example:<br>• The IDT could identify a small group of "retired" individuals with similar interests and begin a coffee club, which would support his interest in coffee, his preference for smaller group activities and promote interaction and relationship development with others with similar interests.<br>• The dietary staff could provide a variety of healthy snacks, with an appropriate diet texture, to accompany the daily coffee, providing teaching as well documentation of preferences.<br>• A regular meeting time could support and reinforce the individual's use of a watch, which the IDT wanted to implement to assist with the toileting schedule. This would allow the individual to use the watch for a preferred and reinforcing activity and potentially increase the likelihood of it being used for self-management.<br>• The coffee club might take field trips to coffee houses around the area to try different types of coffee, which supports community integration as well as preference development.<br>• The coffee club might also have joint events with other clubs that exist in the community, such as at senior centers, further promoting community integration and new relationships.<br><br>The Monitoring Team reviewed the documentation of the ISP Preparation Meeting for the individual. It was noted the staff action plans began with stating an intent to identify a program/plan that would allow the individual to make decisions about activities that would also foster building new relationships while enjoying new activities. The IDT also separately documented each of the singular plans for the issues described above, without stating a plan to develop an approach that would address them in some integrated manner, so it was not clear how the integration would be achieved. It should be noted a coffee club as suggested and described above is just one possible vehicle for integrating the individual's needs, preferences and strengths and was provided only as an example of how an integrated approach could be crafted. The Monitoring Team will look forward to observing how the IDT conceptualizes and implements such integration for this individual at the time of its next visit. | |

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| | | Conclusion: 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; | Adequacy of methods for implementation:<br>The Facility did not yet consistently identify adequate methods for implementation. Examples included:<br>• 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. Examples for findings in Provision S1 indicated that:<br>o Only 14 of the 24 SAPs (58%) included adequate instructions for staff.<br>o Two of the 24 reviewed SAPs (Individuals #4 and #565, 8%) reflected sufficient trials for learning to take place.<br>o Eleven of the 24 reviewed SAPs (46%) reflected an adequate description of teaching conditions.<br>• As reported in Provision M3, for Urinary Tract Infections Acute Care Plans, zero of three (0%) plans included the frequency interventions were to be completed, by whom, and where documented.<br><br>Adequacy of identification of time frames in action plans:<br>For none of the ten ISPs reviewed (0%) did action plans include 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. In two ISPs, the Action Plans indicated only that timeframes were ongoing.<br><br>Adequacy of identification of persons responsible in action plans:<br>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 | Noncompliance |

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| | | Provision F2f which indicated that ISPs, including the completed Action Plans were sometimes not being put into place on a timely manner by those identified as responsible for ensuring plan development.<br><br>Conclusion: This provision was found to be not in compliance. | |
| | 5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and | Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings:<br>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.<br>• As reported in Provision S1, despite some noted improvement, none of the 24 reviewed SAPs (0%) was likely to promote growth, development and independence.<br>• As reported in Provision S3(a), progress had been made toward providing training that was practical and functional for the individual. At the time of the site visit, however, considerable weaknesses remained. Only five of the 14 sampled SAPs (36%) addressed specific needs reflected in formal assessments, and only six of the 14 sampled SAPs (43%) targeted skills that would likely be useful for the individual.<br>• In addition, none of the ten plans (0%) reviewed effectively addressed the individual's full array of needs for services and supports in a manner that was practical and functional across settings. In a number of ISPs reviewed, the document indicated certain SAPs could be implemented in several settings, but it appeared these judgments were not always well thought out by the IDTs. On one hand, a number of SAPS that provided an option for implementation in the community did not appear to be practical or functional in that setting. For example, for Individual #608, SAPs that indicated the community as a location for implementation included asking why the individual used Rogaine and styling hair with 80% accuracy. These appeared to be better suited to implementation in the home. At the very least, discussing individuals' medications would not be an appropriate community activity. The ISP for Individual #565 indicated a program to tolerate tooth-brushing to reduce need for sedation for dental visits could also be implemented in the community. The ISP did not provide enough discussion to determine the individual's current level of tolerance, but it did call into question whether completing tooth-brushing for a resistive individual would be appropriate in a community setting. Indeed, most people living in the community do not brush their teeth in a public setting except in rare | Noncompliance |

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| | | circumstances. In other cases, it appeared that some SAPs could have been functional and practical in the community, but were not designated for implementation in that setting. For example, for Individual #654, a SAP to dry hands after hand-washing could be appropriately implemented in the community in addition to the home and day program, but the community was not designated as a setting for implementation.<br><br>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><br>The ISP did not consistently identify the specific data and/or documentation and frequency of data collection that would permit the objective analysis of an individual's progress. As reported in Provision S1, to assess whether the documentation methodologies were sufficient to produce adequate data collection, 20 SAP data collection forms located in the residences were reviewed. Fourteen of the 20 (70%) included incorrectly recorded data or had missing data. As a result, even though instructions appeared to be adequate, the majority of data forms reflected substantial errors. Findings included:<br>• Ten of 20 data sheets (50%) were missing data for at least one trial.<br>• Ten of 20 data sheets (50%) reflected data recorded for each step in a chaining procedure. Data are only to be recorded for the final step in a chaining procedure.<br><br>In addition, the Monitoring Team requested the SAP data collection sheets for November and December 2013 for the sample of ten recently completed ISPs. This review indicated there was spotty implementation of these SAPs during these recent months. Only three of seven (43%) demonstrated consistent implementation.<br><br>Other examples of deficits in identifying 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 included:<br>• As reported in Provision O2, for zero of five individuals (0%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. For example, Individuals #243 and #305 had PNMT thresholds established but these were not included as part of the IHCP.<br>• As reported in Provision O7, none of 13 (0%) IHCPs contained criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy).<br>• As reported in Provision P2, measurable outcomes were for the most part clearly included as part of the OT/PT plan of service, but were not included as part of the | Noncompliance |

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| | | ISP or ISPA.<br>• As reported In Provision P1, none of 16 assessments (0%) included evidence of the Individual's monitoring schedule<br><br><u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u><br>For ten of the ten ISPs reviewed (100 %), the Action Plans defined the person(s) responsible for data collection. Similarly, for ten of ten (100%) ISPs reviewed, 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.<br><br><u>Conclusion</u>: This provision was found to be not in compliance. | |
| F2b | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP. | <u>Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP:</u><br>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. Other examples of coordination included:<br>• As reported in Provision J3, the Monitoring Team attended the annual ISPs for Individuals #228, #588, and #791 that took place during the week of the visit. 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.<br>• As reported in Provision R2, the SLPs and behavioral services staff 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.<br><br>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. As an example of circumstances in which coordination of services could have been achieved, but was not, as reported in Provision T1b2, the | Noncompliance |

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| | | Facility should have, but did not create 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.<br><br>Conclusion: 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. | Extent to which ISP is accessible to staff:<br>As reported in Provision V1, the Active Records and Individual Notebooks were usually accessible. Audits of 15 records conducted by the Facility in September, October, and November 2013 found 15 (100%) records were accessible. For three of three individuals checked by the Monitoring Team in visits to apartments (100%), the Individual Notebook was readily accessible. For four of five individuals checked (80%), the Active Record was readily accessible. For Individual #413, only one of three charts in the Active Record was present, and locating the others required a search because the checkout book was not present.<br><br>On 1/16/2014, the Monitoring Team also asked eight DSP staff to describe the function of the ISP and to indicate where the ISP report was located. Staff in general were able to describe the ISP as a document that contained information about the individual and their programs; none of those interviewed was able to provide specific information regarding assessments, risk ratings, or the role played by the ISP document in presenting options for living in the community. None (0%) of these staff were able to correctly identify where the ISP report was located. Some staff indicated that the ISP report was in the All About Me book, which was incorrect. Other incorrect responses included that the ISP was emailed to the appropriate staff or that it was posted on a bulletin board near the telephone. Several staff did indicate that they could contact the QIDP for assistance in locating the ISP report.<br><br>Extent to which ISP is comprehensible to staff:<br>The Facility continued to take and/or plan actions designed to promote comprehensibility of the ISP. 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 14 records revealed that that the readability requirement was enforced by the peer review process. | Noncompliance |

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| | | The Facility had also reported at the time of the last monitoring visit a plan to develop two additional tools to improve 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. These had not yet been finalized.<br><br>Overall, 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 ten ISPs reviewed, none (0%) 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.<br><br>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:<br>• As reported in Provision O4, staff were not consistently knowledgeable of the individuals' PNMPs. 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. For example, one of five individuals' positioning plans (20%) was 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.<br>• Staff did not engage in safe mealtime practices per observations conducted by the Monitoring Team; eight of 15 individuals' (53%) dining plans/PNMPs were implemented as written.<br>• As reported in Provision R3, four of nine staff interviewed (44%) were knowledgeable of the individual and their communication related programs.<br>• As reported in Provision F2a6, for a sample of ten recently completed ISPs, only three of seven (43%) demonstrated consistent implementation in November and December 2013.<br><br><u>Conclusion</u>: This provision was found to be not in compliance. | |
| F2d | Commencing within six months of the Effective Date hereof and with | <u>Monthly review of progress</u>:<br>Beginning with ISP annual planning meetings held in October 2013, the Facility required | Noncompliance |

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| | 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. | the QIDP to make an overall monthly review and evaluation of progress rather than a quarterly review. QA/QI data, obtained from the QA/QI Report, dated November 19, 2013, indicated the overall Facility compliance for the Monthly Review Audit had dropped dramatically from 87% in August, 2013 to 5% in both October and November, 2013. This was inconsistent with the data provided in the Self-Assessment which stated that based on review of a sample of 10 QIDP Monthly Review audits, there was evidence that health plans and training documents were reviewed, and that on review of a sample of 6 QIDP Monthly Review audits, 100% were current at the time of the self-assessment. The Director of Quality Assurance (QAD) noted this discrepancy and indicated QA/QI data had not been used for this purpose. The Facility should consider using its ongoing QA/QI data for purposes of self-assessment as it provides a more accurate picture of progress over time than a snapshot that takes place only once. The QAD and Settlement Agreement Coordinator did meet with the Section Lead for Section F to review the data from the monitoring tools. The Facility reported it had initiated a CAP in December 2013 to address the deficits in the QIDP Monthly Review.<br><br>It was clear that the Facility continued to experience difficulties in the implementation of QIDP Monthly Reviews. For ten recent ISPs, the Monitoring Team found the following:<br>• It was difficult to evaluate the actual timely completion of the monthly reviews as many were not signed and dated by the QIDP upon completion.<br>• Some monthly reviews were absent altogether.<br>• In some instances, Monthly Reviews were present but several months were completed on the same date. This lack of timely monitoring made it impossible to revise programs or modify the ISP as needs arose.<br>• Follow-up actions were seldom documented, even when the QIDP stated a plan for follow-up action.<br>• For many Monthly Reviews the same information was repeated month after month.<br>• Even when data were provided, Monthly Reviews provided little evaluation as to progress or need for revision.<br><br>In addition to the review of the ten recent ISPs, the Monitoring Team requested the Monthly Reviews for four individuals who had annual ISP planning meetings or an ISP Preparation meeting during the monitoring visit. Only one (25%) had monthly reviews that were consistently completed in the three months prior to the respective meetings. This rendered effective planning nearly impossible. If the IDTs are not aware of individuals' progress, or lack thereof, they cannot make meaningful plans for the future.<br><br>IDTs as a whole 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. | |

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| | | For example:<br>• As reported in Provision O7, one of the 13 individuals' records in Samples O.1 and O.2 (7%) 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. QIDP 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.<br>• As reported in Provision P2, for individuals with PNMPs or SAPs, for two of 11 individuals in Sample P.1 (18%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly.<br>• As reported in Provision K4, it was evident that the Facility lacked the safeguards necessary to ensure that treatment data were recorded correctly and consistently. Furthermore, it was not clear that treatment decisions were evidence-based or that the Facility possessed the means to ensure that all individuals were provided with the necessary interventions.<br><br>The ISP Preparation 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. It was not clear this process was working as intended. For example, for Individual #228, the ISP Preparation meeting documented the ISP called for the individual to have been referred to participate in choir, a personal desire. This had not been accomplished and was listed as an action step in the ISP Preparation minutes. No action had been taken as of the annual ISP meeting, when this was again listed as a goal. There was no rationale provided for this inaction.<br><br><u>Conclusion</u>: This provision was found to be not in compliance. | |
| F2e | No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall | <u>Policy:</u><br>DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013, requires 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. QIDPs 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 | Noncompliance |

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| | 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. | 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.<br><br><u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u><br>Training sessions for the QIDPs and other IDT members responsible for development of ISPs had been a focus of the Facility in recent months.<br>• The Facilitator Coordinator was developing a series of training modules, which would focus on the following topics:<br>o An overview of person-centered planning, facility and statewide policies and the requirements of the SA as they pertained to the ISP;<br>o The PSI and Functional Skills Assessment (FSA);<br>o Goal-setting;<br>o Living Options;<br>o The QIDP role in completion of the Integrated Risk Rating Form (IRRF);<br>o Rights and Consent<br>It was reported these modules were being offered in small group settings in hopes this would facilitate learning. Each QIDP had completed at least the first two sessions since the initial implementation in the beginning of October 2013. Post-tests were also being developed to assess competency<br>• The QIDPs continued to meet monthly and receive updates and training on a variety of topics.<br><br>While the Monitoring Team did observe some progress during this visit, it was not substantial, as the findings in the rest of this Section suggest. To move in the direction of substantial compliance, the Facility should focus its efforts for the next six months on the following:<br>• 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.<br><br><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 | |

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| | | training for staff responsible for implementation of ISPs. Examples included:<br>• As reported in Provision M4, substantial compliance was found related to competency training for nursing staff.<br>• 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. DSSLC also remained 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 an individual.<br>• 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.<br><br>Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. Examples included:<br>• As reported in Provision O5, the Monitoring Team reviewed three 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 Monitoring Team remained 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.<br>• As reported in Provision M3, for Acute Care Plans (ACPs) and Integrated Health Care plans for skin integrity, three of five (60%) of the Direct Care Support Professional Instruction Sheets included the signatures validating that Home Managers and Direct Support Professionals were trained on all three shifts. Two Direct Support Professional Instruction Sheets lacked signatures for the 10-6 shifts. For urinary tract infections, one of three (33%) plans contained signatures verifying that the respective Home Managers/Charges and DSPs on all three shifts were trained on the DSP Instruction Sheet.<br>• As reported in Provision K12, there was no indication that the Facility had implemented a comprehensive system of integrity checks to assess staff competence in reference to PBSPs and to provide competency-based retraining as needed. The Facility did not present a measure or system for assessing the competence of staff in relation to challenging behaviors that occur infrequently.<br><br>This finding was also influenced by the lack of active treatment and engagement observed | |

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| | | 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, although some progress was noted. See Provision S1, R2 and O4 for examples.<br><br>Conclusion: 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. | Extent to which ISPs are developed within 30 days of admission:<br>The Facility reported seven admissions in the past six months. The Monitoring Team requested a sample of five for review. For five of five (100%), the 30-day ISP meeting was completed within 30 days. For these ISPs, 71% of the assessments were completed at least five days prior to the planning meeting as required. It was noted in particular that the nutritional assessment was missing from two of five ISPs and late in the other three. Four of five PSIs were present and completed at least ten days prior to the planning meeting, a requirement intended to ensure the assessments reflected preferences and strengths. One ISP, for Individual #666, did not have a PSI.<br><br>Extent to which ISPs are revised annually and as needed:<br>In a narrative report provided by the Facility in response to the document request, the Facility indicated the total number of ISP meetings held over the last year period was 485. Four annual meetings were reported to have occurred more than 365 days after the previous annual meeting and all four were reported to be due to hospitalization of the individual. To validate this report, 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. A list of Current/Prior PSP Dates, dated Wednesday, December 04, 2013 was provided. The list indicated the most recent ISP planning meeting for 20 individuals was held more than 365 days following the previous such meeting, although this was the case for only four meetings held in the last six months.. This assessment does not take into account one individual (#576) for whom the database indicated the prior ISP was 9/25/13 and the current was 10/7/13. It was possible this was an entry error and may have represented another ISP that was late during this six month period.<br><br>Extent to which ISPs are put into effect within 30 days of preparation:<br>The document request also asked the Facility to list include the date the most recent ISP was put into effect, but this information was not provided. The Facility responded that the date the ISP document is completed/filed was not being tracked at this time. However, it then went on to state that there is a system to track and report to State Office those ISPs that are not filed within 30 days of the ISP annual planning meeting. The Facility indicated a total number of ISPs that were filed more than 30 days after the annual ISP meeting was held for months of July, August, and September 2013. The data for these months indicated: | Noncompliance |

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| | | • 28 of 47 ISPs (60%) held in July were not filed with 30 days of the ISP meeting;<br>• 17 of the 46 ISPs (37%) held in August were not filed with 30 days of the ISP meeting;<br>• 10 of the 37 ISPs (27%) held in September were not filed with 30 days of the ISP meeting.<br><br>These data appeared to represent a positive trend, but it was unknown if the trend was continuing in the second half of this last six month period. Without a tracking database, it was also not possible for the Monitoring Team to independently confirm or evaluate the data provided. The QAD did indicate that it had taken over the auditing of ISP timeliness in August and had a process in place for providing a deadline for submission directly to the QIDP when an ISP was not filed timely. The QAD further noted that there continued to be some late filings.<br><br>The Monitoring Team continued to observe that even if an ISP was filed within 30 days after the annual meeting, this did not ensure that the ISPs, or portions thereof, were actually implemented. This appeared to be improving, however, as three of five (60%) ISPs reviewed for newly admitted individuals had evidence that implementation occurred within 30 days of the ISP date. There remained concern that SAPs for two of these ISPs held in early to mid-November had not been implemented as of mid-January.<br><br><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 November 19, 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 included a number of monitoring devices related to the Provisions of the section, many of which are referenced throughout this section:<br>• Department and QA audits with the ISP Integrated Monitoring Tool<br>• Analyzing trends in data<br>• Auditing active treatment<br>• Auditing composition and quality of ISPs, SAPs, etc.<br>• Conducting observations of staff implementation of plans<br>• Audits on timeliness of assessments<br>• Audits of scheduling of annual ISP meetings<br>• Audits of assessment quality | Noncompliance |

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| | | • Audits in the homes to determine if staff are correctly implementing plans<br>• CAPs as indicated by results of data collection and analysis<br><br>In addition, the QIDP Coordinator had recently begun to complete an audit of one Functional Skills Assessment per QIDP per quarter to ensure adequate evaluation of the individual's functional skill level, and one Monthly Review audit tool per QIDP per quarter to determine effective coordination of the ISP. One to one feedback sessions with QIDPs were initiated to review audit results for those audits with scores below the desired compliance percentage of 85%.<br><br><u>Conclusion:</u> 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. It did appear that these processes were continuing to develop and better capture meaningful data, although much work remained to be done in terms of identifying and remediating issues to ensure ISPs are developed and implemented consistent with the provisions of this section. | |

| SECTION G: Integrated Clinical Services | |
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| Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. Presentation Book for Section G<br>4. Provision Action Information<br>5. DADS Policy 009.2 Medical Care 5/15/13<br>6. DSSLC Policy CMGMT 03 Integration of Clinical Services 12/1/13<br>7. DSSLC Policy MED-01 Medical Care 8/17/10<br>8. DSSLC Policy Medical-01 Medical Care Exhibit G—Process for Consultations 7/1/13<br>9. Minutes of Integrated Morning Report (IMR) meetings for December 9-13, 2013, and January 13-17, 2014<br>10. Integrated Morning Report Audit Tool of 11/22/13 with meeting minutes and documentation of follow up to a consultation<br>11. IMR audit data and graphs, August 2013-November 2013<br>12. Physical and Nutritional Management Committee (PNMC) minutes and handouts since the last compliance visit<br>13. Materials provided for ISP annual planning meetings for Individuals #567 and #791<br>14. Signature attendance sheets for ISP annual planning meetings for Individuals #567 and #791<br>15. Medical consultation reports for 14 individuals (Individuals #149, #402, #409, #424, #441, #463, #581, #594, #689, #707, #743, #765, #776, and #785)<br>16. Completed medical consultation reports and Integrated Support Plan Addendums (ISPA) for Individuals #583 and #630<br>17. Two tables of attendance at ISP annual planning meetings 8/1/13-11/30/13<br>**People Interviewed:**<br>1. Nancy Condon, Facility Director, Steven Kubala MD, Director of Medical Services, and Dianne Tompkins, Health Services Compliance Coordinator<br>**Meetings Attended/Observations:**<br>1. ISP Annual Planning Meetings for Individuals #567 and #791<br>2. ISP Preparation Meeting for Individual #487<br>3. Change of Status meeting for Individual #567<br>4. Physical and Nutritional Management Committee 1/16/14<br>5. Integrated Morning Report 1/15/14 and 1/16/14<br>6. Admission and Training Review Team 1/14/14 |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section G. 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 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:
  - The monitoring/audit tools the Facility used to conduct its self-assessment included:
    - Integrated Morning Report Audit conducted by the Health Services Compliance Coordinator (HSCC)
    - External and Internal audits: question related to providers' review of consultation
    - HSCC audits of a sample of consultations "regarding presence of required elements of medical and therapy response to consults."
    - Integrated ISP audit conducted by Quality Assurance staff
  - These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. For example, the question on the internal and external audits asked only about whether there is "a clear explanation on the integrated progress notes as to why the provider has chosen not to implement the recommendations" (which has occurred only rarely, as providers generally accept consultant recommendations) but not whether accepted recommendations and action plans are documented. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations.
  - The monitoring tools included adequate methodologies, such as review of Quality Assurance data on clinician attendance at ISP planning meetings, identification of trends being monitored and of corrective action plans (CAPs to address these). However, some methodologies were not adequate. For example, to document that integrated committees continued to meet, the Facility stated this was determined by "attendance or discussion with participants"; it would be better to identify the number of meetings through minutes or other written documentation. To assess participation and integration during clinical meetings, the Self-assessment process was "Attended clinical meetings to participate and observe for signs of integration"; this did not indicate who was to attend which meetings to observe, how many meetings were attended, or whether any data on participation or integration were to be recorded. On a positive note for "signs of integration," the Self-assessment reported on whether recommendations were provided related to specific individuals ("all but two"—but with no indication of the total number of meetings observed) or for systemic changes ("all") and follow-up for previous recommendations ("all").
  - Except for the lack of information on number of clinical meetings attended and observed, 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.
  - The Facility did not provide information in the Self-assessment to allow an assessment of whether monitoring/audit tools had adequate instructions/guidelines to ensure

consistency in monitoring and the validity of the results. For example, there were no definitions of what constituted "discussion with multiple disciplines."
    - The following staff/positions were responsible for completing the audit tools: [List the staff by title
        - HSCC
        - Quality Assurance staff

      Although the auditors responsible for the Internal and External audit were not identified, those can be found in Section L. There was no indication of who observed clinical meetings.
    - The staff identified as 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).
    - Adequate inter-rater reliability was not reported between the various Facility staff responsible for the completion of the tools.
- Used other relevant data sources and/or key indicators/outcome measures. These were limited to attendance at ISP planning meetings and summaries (but not data) on trends in outcomes.
- The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment:
    - Did not present findings consistently based on specific, measurable indicators. For example, data were not provided on integrated discussion in clinical meetings. Data were provided on attendance at ISP planning meetings.
    - Did not measure the quality as well as presence of items.
    - Distinguished data collected by the QA Department versus the program/discipline.
- The Facility rated itself as being in compliance with the following provisions of Section G: Provision G2. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with neither of the provisions. Documentation of review of consultations by Facility medical providers was inconsistent.

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 Completed, In Progress, or (for one action) Not Started. The Facility also identified, for Provision G2, ongoing activities needed to maintain compliance.
- The Facility data identified areas of need/improvement. The Facility identified some actions needed to address these.
- 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 Facility had continued its progress toward providing clinical services in an integrated manner. There was evidence of integrated planning and services for individuals, as well as for systemic improvements. There remained examples in which integrated planning continued to need improvement.

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| | The Integrated Morning Report provided a good opportunity for integrated planning. Much of the meeting involved reporting, and there were a number of individuals or issues for which more in-depth discussion would have been useful. The number of individuals addressed makes it difficult to have extensive discussions. The Facility should address how to encourage active participation about both care of individuals and identification of systemic issues and improvements.<br><br>The Facility had other committees and workgroups that provided opportunities for integrated clinical planning and services, including the Physical and Nutritional Management Team, the Physical and Nutritional Management Committee, and the psychiatric medication review.<br><br>Although the Facility had good policies and procedures, and a standard form, 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, improvements must be made in carrying out these processes. |

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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 Self-assessment reported this provision is not in substantial compliance but that integration is making progress, as "processes exist, data is reviewed, action is taken, and outcomes have shown improvement." Still, the Self-assessment reported "Integration continues to need more improvement in the area of integrated individual planning"; the Monitoring Team agrees with these statements.<br><br><u>Policy</u><br>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." Revisions involved responding to changes in statewide processes for assessments and primarily involved changes in names. The system and structure remained as reported in the last compliance report.<br><br><u>Integrated Morning Report</u><br>DSSLC continued holding the daily Integrated Morning Report (IMR) meetings. This meeting is chaired by the medical director and conducted five days per week. It is an integrated, multidisciplinary meeting with staff from medical and nursing services as well as from other clinical disciplines. There was a standard agenda and format for the meeting. This included the following standard topics:<br>o Provider On-Call Report<br>o Infirmary Report<br>o Hospital Report<br>o Specific Departmental/Discipline Report (with specific reports on Tuesdays, Wednesdays, and Thursdays, such as Admissions and Transitions report each | Noncompliance |

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| | | Wednesday—some are weekly, some scheduled on alternate or every third week)<br>o Follow-Up Items: Individual<br>o Follow-Up Items: Systemic (Wednesday, and more often as needed)<br>o Additional Information Discussed<br><br>The Follow-Up items, implemented since the last compliance visit, were a valuable improvement to the meeting.<br><br>The Monitoring Team reviewed minutes of Integrated Morning Report meetings for December 9-13, 2013, and January 13-17, 2014. The Monitoring Team observed IMR meetings of 1/15/14 and 1/16/14. The Monitoring Team also reviewed audit data provided by the Facility.<br><br>Minutes documented attendance by staff from numerous disciplines, some daily (such as several from nursing and "MED"—apparently physicians) and some periodically (such as pharmacist, Director of Consumer/Family Relations, and Director of Behavioral Services or other behavioral services staff).<br><br>Minutes reported on all individuals in the hospital or infirmary as well as follow-up on individual and systemic issues. One column reported whether the issue was Closed or remained Open. IMR minutes did document follow-up of some items as they were closed. For example, the minutes of 12/10/13 provided a copy of an adverse drug reaction (ADR) report assigned to Pharmacy on 12/9/13 and completed and reported to IMR (along with several other ADR reports completed). This not only provided documentation that the assignment was completed but also provided the information to the rest of the participants for their review.<br><br>In some cases, an issue was closed without documentation of what had been done. For example, sitter issues were reported for Individuals #286 and #551; the plan was for follow-up with the Director of Residential Services. Both of these were closed with no report of what actions had been taken. It would be useful to document actions had been taken (with understanding that the specifics of some actions, especially personnel actions, could not be reported).<br><br>It appeared that issues regarding individuals in hospitals were kept Open so long as an individual was in the hospital. It was unclear, in some cases, whether an action had been taken. For example, for several individuals, there was a statement that staff were following an issue but no report of what "following" actions had occurred. It would be useful to document actions.<br>o For Individual #551, there was a statement each day from 12/9/13 through | |

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| | | 12/13/13 of "HAB following" but no indication of whether any actions had been needed or taken.<br><br>IMR minutes routinely documented referral for Change of Status (CoS) meetings; the December minutes did not document that those meetings had occurred or whether plans had been developed at those meetings; closed items for Individuals #295 and #332 during the meeting of 1/15/14 were documented with dates of CoS meetings, but no documentation of such meetings was provided in minutes for other closed items. The Facility should consider documenting in minutes that the meetings had occurred (and not closing the specific recommendation until this was documented) and, as appropriate and needed, report the plans developed at these meetings or address issues that might need further integrated involvement beyond the IDT.<br><br>The Health Services Compliance Coordinator (HSCC) audits one IMR per month using a standard audit that has seven questions about new items and follow up items. The Facility provided data from audits of the IMR. Also, in response to a request from the Monitoring Team for an example of a completed IMR audit tool that included documentation of an IDT and morning meeting follow-up to a consultation, the Facility provided a completed audit from 11/22/13. Monthly data from August 2013 through November 2013 showed the percentage of applicable questions rated as in place ranged from 83% in August to 57% in November. Thus, the audits found there is room for improvement. The audits should provide information that will assist the Facility in making the most effective use of the IMR.<br><br>Two items were always rated as occurring:<br>o Were all hospital issues referred to appropriate people for follow-up?<br>o Were IDT follow-up items tracked through appropriate referral and/or resolution? Note that either referral or resolution was accepted; it would be better, at a minimum, to track through until the IDT met or took action.<br><br>The audit found one item not occurring in August and September but occurring in October and November; this was whether all change of status items were referred to the IDT. As reported above, the minutes for December 9-13, 2013 and January 13-17, 2014, there was not consistent documentation that CoS meetings had been held prior to closing items; the minutes did document that there was referral.<br><br>Observation of IMR meetings verified the presence of staff from a range of disciplines. The Infirmary report was provided in a handout, and a summary report was made on each individual; the handout provided more detailed information, made the information easy to follow, and provided a hard copy that participants could take with them. This increased the efficiency of the meeting. | |

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| | | Much of the meeting involved reporting, and there were a number of individuals or issues for which more in-depth discussion would have been useful. The number of individuals addressed makes it difficult to have extensive discussions. There were some examples of integrated discussion and planning.<br>o On 1/15/14, there was significant discussion regarding one individual; from the minutes, this appeared to be Individual #435. Decisions were made on the assessments that would be needed and on transfer from a long-term acute care facility to the hospital for a consult.<br>o On 1/15/14, there was discussion during the Individual Follow-Ups agenda about whether IDTs met about two individuals. A staff was assigned to follow up, and the minutes reported the IDTs had met.<br>o On 1/16/14, several participants asked questions or discussed two individuals during the infirmary reports.<br>o Two systemic issues were discussed. On 1/15/14, there was discussion of whether to have a unit for individuals who have traches; this item was then documented in the minutes as Closed. On 1/16/14, there was a report of the status of an open follow up item addressing establishment of criteria for who should live in the infirmary north hall; per the minutes, this topic remained Open. Both of these were primarily reports of the current status of planning.<br><br>Overall, the IMR process provides information to keep many clinical disciplines aware of the status of individuals, as well as opportunities for integrated discussion that could improve the care provided (both to individuals and systemically). Although reporting of information is useful, the Facility should take care to encourage active participation about both care of individuals and identification of systemic issues and improvements.<br><br><u>Integrated Committees and Workgroups</u><br>The Facility had several committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues, including the following:<br>• 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 related to physical and nutritional management as well as other clinical care issues such as falls and incidence of pneumonia.<br>o As reported in Section O, an adequate Physical and Nutritional Management Team (PNMT) was no longer in place as participation by the PT and the RD was less than 60% and 50%. Failure to have | |

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| | | consistent participation results in non-interdisciplinary approach to PNM care.<br>o Membership of the PNMC included the Facility Director, Assistant Director of Programs, Medical Director, Habilitation Therapies Director, Chief Nurse Executive, RN Case Manager Supervisor, PNMT OT, Director of Residential Services, Infection Control Nurse, and Director of Quality Assurance, thus providing an integrated management-level review and action-planning process. In addition, other staff had attended meetings for specific topics and had been involved in initiatives established by PNMC. The PNMC had routinely reviewed trends in clinical indicators related to pneumonia and respiratory infections, hospitalization, skin integrity, mobility status, infections, and falls; minutes reflected instances in which information was specific to certain units and apartments, which led to localized actions. Initiatives established by, and topics reviewed by, PNMC included selection of dining chairs to improve positioning, trach care and establishment of specialized residential locations, use of a variety of clinicians and other staff as meal mentors, revising meal menus and delivery of food at three houses identified with constipation issues, and seasonal variations in hydration, among others.<br>• The Facility Admission and Training Review Team involved participation by the Facility Director, Director of Residential Services, Chief Nurse Executive, Habilitation, Director of Behavioral Services, QIDPs, Unit Nurse Managers, and others. This team reviewed and discussed the need for supports and services for potential admissions from both other SSLCs and the community, as well as post-move monitoring for individuals who had recently moved or for whom a move was anticipated. This meeting has the potential to improve the immediacy of providing appropriate supports to newly admitted individuals and of responding to issues that may emerge when people transition out.<br>• As reported below, the psychiatric medication reviews (PMRs) included participation by nursing, QIDP, DSP, in some cases the guardian and the psychologist/behavior analyst.<br><br><u>Integrated Planning and Services for Individuals</u><br>Integrated planning requires disciplines to 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 and a variety of routinely scheduled cross-discipline meetings.<br>• As reported in Provision R2 for a sample of individuals who had Positive | |

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| | | Behavior Support Plans (PBSPs) and communication deficits, there was evidence that SLPs reviewed PBSPs consistently, and that communication strategies identified in communication assessments were included in both the PBSP and ISP. SLPs regularly participated in meetings of the Positive Behavior Support Committee. In addition, 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.<br>• As reported in Provision J1, a new document had been implemented, the Integrated Behavioral Health Plan (IBHA). One aspect of this document was organization of the document to include psychiatric formulations, then behavioral formulations, and finally integrated findings for both provided a natural flow to the presentation. The Monitoring Team found the new/expanded sections on integrated findings and combined recommendations to contain the elements needed to guide integrated treatment.<br>• As reported in Provision J1, psychiatric medication reviews (PMRs) included participation by nursing, QIDP, DSP, in some cases the guardian and the psychologist/behavior analyst. As reported in Provision J8, the Facility had many places in the clinical process where psychiatrists, psychologists, and other IDT members worked side-by-side to generate the combined assessments and case formulations required by this provision. Some of these were the PMR clinics, medical reports, and ISP meetings. In general, Monitoring Team observations of PMRs indicated that there was good multidisciplinary participation and, for the most part, good interdisciplinary examination of the relevant clinical issues. Integrated care at the level of the behavioral team continues to improve, as have the gleanings of information from the behavioral team for use by the broader IDT, for example in the ISP.<br>• The Monitoring Team attended the ISP annual planning meeting for Individual #588. The behavioral health care plan had contributions from psychology and psychiatry via the IRFF and the remainder of the ISP, the team was familiar with the details of the care and the primary care physician and psychiatrist had exchanged information and were familiar with each other's contributions.<br>• During a pre-ISP meeting for Individual #487, discussion about weight was integrated across disciplines and across possible causes of weight loss and assessments needed.<br>• As reported in Provision M1, after the Skin Integrity Nurse completed individuals' wound assessments, their status were reported to the respective primary nurses, charge nurses, RN Case Managers, and primary care providers. The Skin Integrity Nurse worked collaboratively with the physical and occupational therapists regarding the need for positioning adjustments or other | |

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| | | assessments, as well as when wounds were healed to assess for preventative measures.<br>• The Monitoring Team attended Individual #567's ISPA Change of Status (CoS) for Anemia meeting. All of Individual #567's relevant IDT members attended the meeting. The primary care provider led the meeting and gave an account of his past and present medical conditions. The IDT actively participated in discussing and reviewing Individual #567's CoS and then reviewed and discussed revisions to the IRRFs for anemia and fluid imbalance risk ratings, as well as the development of IHCPs to reduce these risks.<br><br><u>Interdisciplinary Team (IDT) Attendance, Participation, and Clinical Planning</u><br>For integrated planning to occur, clinicians must participate in interdisciplinary meetings, such as the ISP annual planning session. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the annual planning meeting.<br><br>The Facility's self-assessment reported that attendance at 168 ISP meetings showed attendance of clinicians ranging from 77% for speech language pathologists (SLPs) to 100% for physical/occupational Therapists, behavior specialists/BCBAs, and audiologists, based evidently on who was required per the ISP Preparation meeting. Dental was not required to attend any meeting per IDT, but the self-assessment reported their input could have been valuable.<br><br>The Facility provided two tables of attendance at ISP annual planning meetings. One table listed a number of disciplines (some clinical and some non-clinical such as home staff) and had columns for Count of Attendance, Total Required, and Percent of Attendance. The other listed a larger number of participants, including some duplicated positions such as multiple rows for "Day Programming/Retirement Programing" and "Home Manager," "Home Manager/Supervisor," and "Home Supervisor." The second table listed the "Sum of Total Meetings" that varied across attendees, so this likely was the number of required meetings rather than the total. There were columns for the number attended and for the number who attended whole versus partial meetings. The data did not match; the total numbers for which a "Direct Contact Professional" and "Individual" were required in the second table were 111 and 112 respectively. Since both are generally expected to attend (although, understandably, the individual may choose not to attend), 112 should be the total number of such meetings, whereas the total required on the first table was 168. The first table reported that "Home Staff" attended 167 of the 168 meetings (99%) as contrasted with the 111 reported on the other table. Thus, it was difficult to know exactly how many meetings occurred, how many each discipline was required to attend, and the percent of those attended. Nonetheless, both reported that attendance by clinical disciplines was high. On the first | |

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| | | table, the only clinical disciplines with attendance less than 90% were Vocational Services (31%) and Speech/Communication Therapist (77%). On the second table, all were reported to attend at greater than 90%, with both Vocational Services and "Communication Therapist (Speech)" attending 100% of required meetings. The Facility must ensure it has accurate and consistent information about attendance at these meetings. The Monitoring Team cannot make a confident assessment as to the actual attendance.<br><br>The Monitoring Team observed ISP annual planning meetings for Individuals #567 and #791 and reviewed attendance sheets. The Monitoring Team did not review the ISP Preparation meeting to determine required attendance; however, the signature sheets contain a column with boxes to check who was required. Attendance at both meetings was appropriate to the needs of, and services provided to, the individual. All required clinicians were in attendance at both meetings, along with several other required and non-required participants. Attendance was therefore consistent with the data reported in the Self-assessment.<br><br>As reported in Provision F1b, signature sheets (and, therefore, data on participation taken from signature sheets) sometimes failed to convey the actual participation of IDT members. For the ISP annual planning meeting for Individual #228, two Speech Language Pathologists (SLPs) and a Behavioral Health Specialist (BHS) were both in attendance, but for only portions of the meeting. As a result, the IDT did not have the opportunity to have a full discussion of the individual's communication and behavioral needs, which were complex.<br><br>Observations of ISP annual planning meetings indicated discussion and participation by many IDT members, not only clinicians, but also direct support professionals (DSPs). For the ISP annual planning meeting for Individual #567, in particular, the Monitoring Team was extremely impressed with a DSP in attendance during the second half of the meeting. She was very knowledgeable about the individual, offered insights and suggestions and contributed tremendous value to the interdisciplinary process.<br><br><u>Examples of Improvement Needed</u><br>Although clinical services had become much more integrated over time, examples remained which demonstrated a need for continuing improvement.<br>• As reported in Provision K5, although the PMR included several disciplines, and there were other examples of collaboration among psychiatric and behavior services staff, the behavior and psychiatric assessments for Individual #753 contained conflicting information and targeted the same behavior without rationale showing how the interventions complemented each other or addressed different aspects of the behaviors. | |

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| | | • Although back-up members had been identified, attendance by Physical Therapy and the Dietitian at meetings of the Physical and Nutritional Management Team (PNMT) were low, as reported in Provision O1. This resulted in the PNMT not having information that could have been important for decisions about treatment and interventions.<br><br>Improvement continued to occur in integrated planning, and the Facility was approaching a level of integrated planning that could be in substantial compliance. The Facility needs to ensure that collaborative case formulation is clearly documented, that the clinicians (and, at times, the IDT) identify discrepancies or inconsistencies among assessments for an individual, and that there is clear evidence of interdisciplinary contribution of services and interventions for chronic conditions. | |
| 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><br>DADS Policy 009.2 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.<br><br>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. Exhibit G for the Medical Care policy 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 policy and exhibit identify the responsibilities for completing required actions and the flow of actions from a request for a consult to return of the completed consultation form. Exhibit G does not address referral to the IDT.<br><br><u>Procedures and Forms</u><br>The Facility used a standard consultation form. 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. | Noncompliance |

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| | | The Facility provided consultation reports and ISPAs for Individuals #583 and #630 as a sample.<br>• Individual #583: The consultant provided a recommendation (in addition to a thorough explanation). The form was signed and dated by a facility primary care provider (PCP). On the second page, the PCP had checked "Adopt Consultant's Recommendations" and that this was to be referred to the IDT. An ISPA documented a substantive review that resulted in both agreement to implement the recommendation for a trial period (during which the IDT recommended the individual remain in the infirmary) and also recommended a meeting following the trial to discuss the outcome of the trial and consider a move to a different living unit that had a higher level of support specific to the individual's needs.<br>• Individual #630: The reason for the consultation (which was actually an injection as treatment for a condition) was stated on the report, and the consultant's recommendation for repeat if desired was written. The form was signed and dated by a facility primary care provider (PCP). On the second page, the PCP had checked "Adopt Consultant's Recommendations," checked that this was to be referred to the IDT, and wrote the recommendation the consultant had made. The PCP signed and dated this page. The ISPA documented a substantive review that indicated the injection did not appear to be effective, with a plan to postpone additional injections until additional information could be gathered.<br><br><u>Review of Consultations by Facility Clinicians</u><br>The Facility provided data from external and internal medical audits for the following question: Are medical and/or surgical consultation recommendations addressed in the Integrated Progress Notes within five business days after the consultation recommendations are received. These data were for August-November 2012, February-Mary 2013, and August-November 2013. For the period covered by this compliance visit, August-November 2013, the internal review found 86% of consultation recommendations addressed in IPNs, and the external review found 93%. As noted below, this was not consistent with the findings of the Monitoring Team regarding medical consultations.<br><br>The Facility also provided a graph of HSCC audits for Provision G2 from October 2012 through December 2013. These graphs showed a steady increase in completion of requirements that leveled off beginning March 2013 with all months showing completion between 75% and 100%. An explanation stated that declines in completion were explained by not checking the box regarding if the matter should be referred to the IDT, and that corrective action had been taken. However, for three consultations in December 2013 reviewed by the Monitoring Team from the sample below, none documented | |

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| | | referral to the IDT.<br><br>Review by the Monitoring Team: The Monitoring Team reviewed a sample of 12 medical consultation reports for nine individuals (Individuals #149, #409, #424, #441, #594, #707, #743, #776, and #785) and five Modified Barium Swallow Studies (MBSS) for Individuals #402, #463, #581, #689, and #760.<br>• For the medical consultations:<br>o Six of 12 (50%) had evidence of review by a PCP.<br>▪ Six of 12 (50%) had evidence on the consultation form of review by a PCP (initials and date). Two (17%) had a progress note in the Integrated Progress Note (IPN) section of the Active Record.<br>▪ Five (42%) documented acceptance of the recommendations either on the form or in an IPN; one did not document acceptance or rejection.<br>• For the MBSS consultations:<br>o Five of five (100%) documented review with a progress note in the IPN completed within five business days; the Monitoring Team did not check to determine whether the PCP had initialed the consultation report itself.<br>o Five of five (100%) documented acceptance of the recommendations.<br>• Overall:<br>o Eleven of 17 (65%) documented review by a Facility clinician, through either a notation on the consultation report or an IPN, or both.<br>o Ten of 17 (59%) documented acceptance of recommendations.<br><br>None of the sampled consultations were found to have a referral to the IDT. However, the IMR minutes included a column for referral. There was not, however, a requirement that all consultations be reported to the IMR. Therefore, the Monitoring Team could not determine whether there were few referrals to the IDT or whether there was another process that would ensure referrals would occur as needed.<br><br>As stated in the report of the last compliance visit, 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 | |
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| Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan for 12/5/13<br>3. Presentation Book for Section H<br>4. Provision Action Information updated 12/13/13<br>5. DADS Policy 004.2 Individual Support Plan Process 11/21/13<br>6. DSSLC Policy CMGMT 03 Integration of Clinical Services 12/1/13<br>7. DSSLC Policy MED-01 Medical Care 8/17/10<br>8. DSSLC Quality Assurance Plan 9/24/13<br>9. DSSLC Quality Assurance Plan Key/Clinical Indicators (undated)<br>10. QA/QI Council Data Review Meeting documentation for 8/26/13, 9/24/13, 10/29/13, 11/19/13, 1/14/14<br>11. Physical and Nutritional Management Committee (PNMC) minutes and handouts since the last compliance visit<br>12. Minutes of Integrated Morning Report (IMR) meetings for December 9-13, 2013, December 31, 2013, and January 13-17, 2014<br>13. Minutes of Providers' Meetings of 8/20/13, 10/9/13, and 11/13/13<br>14. Share Drive information on assessments for Individual #299<br>15. Document "ISP ASSESS DATA BY APT-UNIT 2012" including table of overall percent of compliance April 2012-November 2013, table of compliance by assessment April 2012-November 2013, and a number of graphs by discipline and assessment<br>16. Table of "Compliance by Unit and Individual—Annual Assessments Filed 10 Days Prior to PSP" by assessment for each unit for PSP Dates 11/1/13-11/30/13<br>17. List, by condition, of any standardized clinical indicators routinely used to assess progress or status of individuals with chronic healthcare conditions<br>18. Risk Action Plan and Clinical Indicators/Data Considerations (undated but in response to a request for "Revised PNM clinical indicators list developed following October aspiration pneumonias")<br>19. Health Services Compliance Coordinator (HSCC) Medical Record Audit list of items and relevant provisions and graphs<br>20. Assessment of Assessments Medical Review for Individual #699<br>21. Sample list of clinical indicators for QIDD clinical indicator review<br>**People Interviewed:**<br>1. Nancy Condon, Facility Director, Steven Kubala MD, Director of Medical Services, and Dianne Tompkins, Health Services Compliance Coordinator<br>2. Diane Tomkins, Health Services Compliance Officer/Coordinator (HSCC)<br>**Meetings Attended/Observations:**<br>1. ISP Annual Planning Meetings for Individuals #567 and #791<br>2. ISP Preparation Meeting for Individual #487 |

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| | 3. Change of Status meeting for Individual #567<br>4. Physical and Nutritional Management Committee 1/16/14<br>5. Integrated Morning Report 1/15/14 and 1/16/14 |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section H. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.<br><br>For Section H, in conducting its self-assessment, the Facility:<br>▪ Used monitoring/auditing tools. In some cases, the Facility reported an audit was done but did not indicate if a specific tool was used (for example, "psychiatry audits of CPAs and Annual Psychiatric Summaries). 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:<br>o The monitoring/audit tools the Facility used to conduct its self-assessment included:<br>▪ Assessment of Assessments, including Medical Management Assessment of Assessments<br>▪ External Medical Audit<br>▪ Internal Medical Audit<br>▪ Section I-At Risk Individual monitoring tool<br>▪ Audits completed for other Sections of the Settlement Agreement, including audits of psychiatric assessments and annual summaries, nursing assessments, OT/PT assessments, and behavioral assessments<br>o These monitoring/audit tools generally included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. Note that the Section M report identifies concerns with the extent of content of the external and internal medical audits; for a full review of whether tools included adequate indicators, please review each Section summary of the Self-assessment. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations.<br>o The monitoring tools included adequate methodologies, such as document reviews and observations of meetings.<br>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). These sample sizes were adequate to consider them representative samples.<br>o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. For tools used for specific Sections of this agreement, the Section summaries of the Self-assessment have further information.<br>o The following staff/positions were responsible for completing the audit tools: the HSCC and relevant external consultants and clinical staff. |

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| | ○ 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).<br>○ Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of some tools but had not for others. Reliability was not reported for HSCC audits and Assessments of Assessments; review summaries of the Self-assessment for various Sections of this report for information about reliability.<br>▪ Used other relevant data sources and/or key indicators/outcome measures, including:<br>○ Timeliness of assessments<br>○ Completion of Interrater reliability checks, and the average reliability<br>○ Completion of progress notes<br>▪ The Facility consistently presented some, but not all, data in a meaningful/useful way. Specifically, the Facility's Self Assessment:<br>○ Generally presented findings based on specific, measurable indicators. However, for "trended outcome data," the Self-assessment summarized the trends but did not provide data. The Self-Assessment noted graphs and more information would be provided in the presentation books on-site.<br>○ Consistently measured the quality as well as presence of items. For example, the Facility reported percentages of compliance of medical assessments using the assessment of assessments tool.<br>○ Distinguished data collected by the QA Department versus the program/discipline.<br>▪ The Facility rated itself as being in compliance with no provisions of Section H. This was consistent with the Monitoring Team's findings.<br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>▪ Actions were reported as Completed or In Progress<br>▪ The Facility data identified areas of need/improvement. Some actions specifically addressed issues noted in the Self-assessment as needing progress. For example, for Provision H1, the Facility stated "further progress is needed for quality and timeliness of some assessments." In the Action Plan, the Facility stated an action of "Use timeliness of assessment data for ongoing change including during quarterly QAQI meetings" and also had the same action using "assessment of assessment data."<br>▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Although the Action Plan addressed most areas identified as needing improvement, the actions themselves were often general and did not identify sequential steps to achieve compliance. The examples above that stated the Facility would use data on timeliness and from the assessment of assessments did not indicate any specific actions or description of how these data would be used, and of what actions were being taken to improve. |
| | **Summary of Monitor's Assessment:**<br>The Facility continued to take action to improve timeliness and use of clinical indicators. Nevertheless, although the Facility had approached substantial compliance with some provisions of this Section at the |

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| | last compliance review, there had not been progress substantive enough to achieve substantial compliance with any provision. Although there were numerous venues to review clinical indicators, and there were efforts to address systemic issues, there remained areas in which clinical indicators were not used to identify needs for revisions to treatments and interventions and implement them.<br><br>**Provision H1:** Timeliness of assessments continued to be high overall but variable across departments, according to Facility data. However, review by the Monitoring Team found a larger number of assessments that were not completed according to policy. Comprehensiveness of assessments, while improved for several disciplines, had not improved for others. Furthermore, use of assessment data to make decisions on treatments, supports, and services was variable. The new standardized format for assessments has the potential to improve comprehensiveness of the assessment reports if the underlying assessment practices also improve.<br><br>**Provision H2:** Both medical and psychiatric diagnoses were consistent with diagnostic coding standards. Psychiatric diagnoses were consistent with the information contained in the psychiatric evaluations.<br><br>Medical diagnoses were more variable. A significant concern was the stratification of diagnosis of pneumonia, pneumonitis, and bronchitis, and especially aspiration pneumonia. In some cases, a diagnosis may have been accurate based on the assessments done, but additional assessments would have been appropriate and useful to identify etiology or to confirm the diagnosis.<br><br>**Provision H3:** Timeliness of implementation continued to improve in many areas but remained variable. In general, treatments and interventions were based on assessments and were clinically appropriate. As noted in the examples below, this was not consistently the case.<br><br>**Provision H4:** The use of clinical indicators to determine efficacy of treatments and interventions continued to expand; there remains a need to ensure review of clinical indicators is routinely done for common and serious chronic conditions. At the same time, as reported in Provision H3, there remained cases in which treatments and interventions were not assessed for efficacy or in which decisions on treatment were not based on data on clinical indicators. To achieve substantial compliance, the Facility must track (especially for individual and, as selected, for system-wide review) indicators of health status that can be used for proactive decision-making, and must ensure decisions are made based on the indicators.<br><br>**Provision H5:** The Facility is approaching substantial compliance with this provision. The Facility had continued to use or had established several systems to monitor the health status of individuals. Monthly monitoring by the QIDP was not consistent and did not regularly include analysis of progress. An area for improvement remains ensuring monitoring is done regularly and documents progress or regression based on data and other information.<br><br>**Provision H6:** Modification of treatments and interventions in response to clinical indicators was variable. In some cases, this was done effectively and timely. In other cases, clinical indicators were available and |

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| | were tracked, but they were not reviewed and assessed for need for revision of treatment or did not result in revisions. In other cases, clinical indicators were not tracked.<br><br>**Provision H7:** The Facility had local policies that provided requirements for completing assessments and for minimum standards of clinical care relevant to the requirements of this Section, such as use of clinical indicators. DADS had a draft policy but had not finalized it. DADS and DSSLC policies on the Integrated Support Plan included requirements for completion of assessments. |

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| H1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs. | The Provision Action Information listed a number of actions taken. These included:<br>• Training to improve medical care<br>• Developed an audit tool for medical management review<br>• Conducted External and Internal Medical Quality Assurance and Medical Management Audits<br>• Audited the timeliness of Chronic Care Quarterlies for two Primary Care Providers (PCPs)<br>• Revised the HSCC Audit tool<br>• Trained medical providers in the new Annual Physician Summary format<br>• Reviewed "the new State Office policy draft of 'Minimum Common Elements of Clinical Care' and provided feedback to the State Office<br>• Provided feedback to the PCPs on the expectation of their active role in PNMT meetings<br><br>All these may be useful actions. To address the requirements of this provision, the actions needed to result in improved timeliness of assessments both on a regular basis and in response to changes in status.<br><br><u>Policy</u><br>DADS Policy 004.2 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 and no later than five days prior to the initial admission ISP.<br><br><u>Extent to which assessments are conducted routinely</u><br>In its Self-assessment, the Facility reported that timeliness of assessments is continuing to improve but that further improvement was needed. A table listed 10 assessments and the percentages completed timely each month from August 2013 through November 2013 (as well as percentages each month back to April 2013, and the month of April 2012); the percentages during the four months since the last compliance visit for specific assessments ranged from 71% to 100%. | Noncompliance |

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| | | As reported in Provision F1c, the Facility provided an updated facility-wide table by assessment (for 12 assessments) of timely completion percentages for the months of August 2013 through December 2013. The range for specific assessments was from 58% to 100%.<br><br>The Facility provided tables and graphs of assessment timeliness by discipline/assessment and unit. The range by discipline/assessment (evidently—from review of the other tables—for November 2013, but the table did not have a heading to explain) was from 58% for the Functional Skills Assessment to 100% for Pharmacy. For the months of August 2013-November 2013, the monthly averages for all assessments ranged from 84%-90%. These data would indicate an acceptable range for timeliness when considering all assessments but not when considering specific assessments that would provide needed information for decision-making at the ISP planning meeting. Review of the graphs and tables revealed timeliness routinely at or approaching 100% for Pharmacy and Vocational Services but often below 80% for Self-Administration of Medication, PA/FA, and Nursing.<br><br>The Facility also provided a table for November 2013 that listed, for each individual who had an ISP meeting that month, whether each assessment was filed 10 days prior to the "PSP." According to interview, this meant 10 working days prior to the annual ISP planning meeting. For each assessment, the cell for each individual was either filled with "Yes" or "No" or was blank (presumably meaning it was not required, but that was unclear, and the headings for the specific assessments were not clear on the provided document). The table included a total percent of compliance for each individual and for each unit. The percent compliant for individuals ranged from 58% to 100%. The percent compliant for units ranged from 79% to 91%.<br><br>Also reported in Provision F1c were the results of review of timeliness of assessments overall for a sample of ten completed ISPs as well as for an upcoming ISP annual planning meeting. This review showed improvement since the previous compliance visit, but further improvement is needed.<br><br>Thus, as reported in Provision F1d, assessment practices at DSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. Although improved, assessments required to develop an appropriate ISP meeting were not consistently done in time for QIDPs 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. | |

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| | | Findings by the Monitoring Team included:<br>• As reported in Provision R2, assessments/updates were consistently dated as having been completed at least 10 working days prior to the annual ISP. For 10 of 10 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP.<br>• As reported in Provision K5, DSSLC had not maintained previous progress in ensuring that Psychological Evaluation reports contained the necessary test results. In the sample of 14 individuals, the following issues or weaknesses were noted.<br>• Only two of 14 individuals (14%) had been provided with a current intellectual assessment. This reflected a decrease of 66% in comparison with the previous site visit.<br>• Ten of 14 individuals (71%) had been provided with a current assessment of adaptive behavior. Although better than ratings regarding the intellectual assessments, this reflected a decrease of 29% in comparison with the previous site visit.<br>The Facility also provided global data regarding intellectual and adaptive skill assessments. A review of those data reflected the following issues.<br>• Thirty-eight of 494 individuals (8%) were reported to have an intellectual assessment.<br>• Data reflected that 468 individuals were provided with a formal assessment of adaptive skills. For 120 of those individuals (26%) the assessments were over one year old. For 152 of those individuals (31%) the associated report was either over one year old (n=120, 26%) or the assessment was less than a year old but there was no report (n=32, 5%).<br>• As reported in Provision K7, individuals admitted to the Facility were not routinely provided with the necessary psychological assessments. Information provided to the Monitoring Team prior to the site visit reflected that six individuals were admitted to the Facility since the previous site visit, Individuals #280, #281, #459, #666, #668, and #800. Facility tracking spreadsheets reflected that only two of these individuals (Individuals #280 and #666, 33%) had been provided intellectual and adaptive assessments, with only Individual #666 having being provided an assessment report. Facility tracking spreadsheets reflected that none of the six recently admitted individuals (0%) had been provided with behavior assessments. Despite the tracking data presented above, the Facility provided written reports for three of the six recently admitted individuals (Individuals #280, #459, and #666, 50%). Based upon the three submitted reports, the following circumstances were noted.<br>• One of six recently admitted individuals (Individual #280, 17%) was provided | |

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| | | with intellectual and adaptive skill assessments within 30 days of admission.<br>• Three of six recently admitted individuals (Individuals #280, #459, and #666, 50%), were provided with behavior assessments within 30 days of admission.<br>• Three of six recently admitted individuals (Individuals #280, #459, and #666, 50%), were provided with psychological assessment reports within 30 days of admission.<br>• As reported in Provision R2, although assessments and updates were timely, not all individuals requiring comprehensive assessments had yet received them. 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. The Facility did define the timeframe for the completion of communication assessments for individuals within their defined priority levels. The plan calls for all individuals to have received a comprehensive assessment by December 2015 but per interview, it was expected that this goal might be reached December 2014. At the time of this visit, assessments had been completed for priority groups 1, 2, and 3, with completion of assessments for priority groups 4 and 5 expected by the end of the year.<br>• As reported in Provision V4, the Monitoring Team also viewed the assessments available on the shared drive for Individual #299, who had an annual ISP meeting scheduled within the next ten working days. For 19 assessments that were required per the ISP Preparation meeting, 12 (63%) were available. This was not consistent with the compliance rate reported in the tables for Sections F and H.<br>• As reported in Provision J7, two hundred forty of the 469 individuals residing at the Facility received ongoing support from the psychiatry clinic, and all of those individuals had psychiatric evaluations in place. Between 7/26/2013 and 12/09/2013 there were five admissions. These were Individuals #251, #280, #459, #666, and #800. All of the individuals were admitted with a psychiatric diagnosis or were taking psychiatric medications. Each of the individuals received a psychiatric evaluation soon after admission. In no case was the delay longer than 2 ½ weeks.<br>• As reported in Provision O2, the majority of annual nutritional assessments were not provided in a timely manner for review by the IDT.<br>• As reported in Provision P1, fifteen of 16 individuals' OT/PT assessments in Samples P.1 and P.2 (94%) were dated as having been completed at least 10 days prior to the annual ISP. Seven of seven admitted individuals since the last review (100%) received a comprehensive OT/PT assessment within 30 days of admission or readmission. DSSLC does not do screening upon admission for OTs and PTs but, instead, conducts a comprehensive OT/PT assessment. The | |

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| | | Monitoring Team considers the presence of assessments as meeting and surpassing compliance with this metric.<br><br><u>Comprehensiveness of Scheduled Assessments</u><br>The Facility had begun using statewide standardized assessment templates for clinical assessments. These assessment templates included a set of standard sections that should be consistent from discipline to discipline. The topics appear to cover the needed areas that should be included. Within many sections, each template had specific information headings or boxes that needed to be completed. For example, the History section of the Biopsychosocial Assessment included a number of boxes for demographic information and for legal information, a place to list information on correspondents, a section for resident and family history with subheadings for Communication and Home Environment, Developmental History, and Trauma History. Other sections likewise included topics to specify the needed information. It will be important that the quality and comprehensiveness of the content of those sections be accurate and adequate for decision-making. Use of these templates had just begun, so evaluation of their quality and effectiveness in informing decision-making will await the next compliance visit. Review of assessments that were conducted both prior to and following implementation of the new format indicated variation in comprehensiveness.<br>• As reported in Provision J6, comprehensiveness was variable, ranging from insufficient to adequate. Because comprehensive psychiatric evaluations (CPEs) have long been in place at DSSLC, many older assessments need to be revisited to ensure all required components are in place.<br>• As reported in Provision K5, psychological assessments did not consistently include summaries of how results would facilitate the understanding of the individual's strengths and needs, and this had regressed compared to the last compliance visit. Behavioral assessments were more variable, with outstanding examples but not evidence of acceptable practices being implemented Facility-wide.<br>• As reported in Provision P1, there was significant improvement in comprehensiveness of OT/PT assessments, which included most required components. Further improvement was evident in assessments completed using the new standardized format that was initiated in October 2013.<br>• As reported in Provision Q1, annual dental assessments consistently evaluated oral hygiene, periodontal disease, plaque, and gum health, as well as level of restraint required to perform dental examinations and treatments, but did not consistently document condition of teeth.<br>• As reported in Provision R2, communication assessments did not yet include all required components. The new standardized format that was initiated in October 2013 appears to have addressed the missing components but the | |

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| | | sample in which these were noted was small and will need to be reviewed during the next compliance visit to ensure full implementation of the new assessment.<br><br><u>Assessments in Response to a Change of Status</u><br>The Facility had processes in place to address changes in status. These included the Change of Status meeting, referral to the Physical and Nutritional Management Team, referral for Reiss Screens whether there is a behavioral change, and discussion and the Integrated Morning Report.<br><br>The Monitoring Team attended Individual #567's ISPA Change of Status (CoS) for Anemia meeting. All of Individual #567's relevant IDT members attended the meeting. The IDT developed an action plan that included additional assessments.<br><br>As reported in Provision J7, there were two referrals to psychiatric services for individuals not receiving psychiatric treatment and a psychiatric assessment was completed. In each case the protocol was followed.<br><br>As reported in Provision O2, five of five 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). There was concern that if the individual was not referred to the PNMT, assessments were not always completed as identified by the IDT. For example:<br>• Individual #211 has a history of repeated emesis and respiratory illnesses but there was no evidence of a Head of Bed Assessment or review by the PT to determine if the current degrees of elevation remained appropriate.<br>• Individual #243's IDT recommended the OT re-assess Head of Bed elevation post Aspiration Pneumonia but there was no evidence that this occurred.<br><br>As reported in Provision K5, for Individual #637, the most recent behavior assessment report was dated 7/23/2013. Although data current at the time of that report were included, many of the actual assessments presented were one to three years old at the time of the report. In circumstances where an individual had experienced few changes, it might be possible to use older assessments. In the case of Individual #637, however, the report indicated that the individual had experienced substantial changes in personality and independence within the previous 12 months. As a result, it was unlikely that older assessments would be sufficiently accurate to provide the information necessary to develop a behavior intervention.<br><br><u>Use of Information from Assessments</u><br>Examples were found both of use of information from assessments and of lack of use of | |

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| | | the information.<br>• 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.<br>• As reported in Provisions S1 and S3a, it was not always clear that information from assessments was considered when establishing specific skill acquisition objectives or developing methodologies to teach skills, although there was some indication of improvement in comparison with previous site visits. For example:<br>• Functional Skill Assessments (FSAs) for five of 14 SAPs (36%) reflected evidence to support the reviewed SAP, an improvement compared to the last compliance visit.<br>• According to the Functional Skills Assessment (FSA), Individual #637 lacked an understanding of the purpose of a clock and could not tell time. The skill acquisition plan (SAP), however, called for the individual to use a clock in order to determine when it was time for specific events. As a result, there was no practical means for the trainers to implement the SAP.<br>• The SAP for Individual #734 targeted choosing a magazine. The FSA reflected that the individual requires total staff assistance and lacks the ability to indicate a choice. The ISP narrative stated that the individual consistently failed to respond to questions or requests. There was no indication in any documentation that the individual was interested in magazines. Therefore, it was not reasonable to expect that the SAP was practical for the direct support staff to implement.<br>• As reported in Provision F1d, even when the results of this 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.<br><br>Thus, improvement continued to occur. Timeliness had improved but required additional improvement. The new standardized format for assessments has the potential to improve comprehensiveness of the assessment reports if the underlying assessment practices also improve. | |
| 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 | <u>Policy</u><br>DSSLC Policy CMGMT 03 Integration of Clinical Services requires clinicians to be responsible for accurate and complete diagnosis coding.<br><br><u>Diagnoses are consistent with standards</u><br>Medical diagnoses in annual medical assessments were consistent with appropriate ICD-9 diagnoses. | Noncompliance |

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| | Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. | Psychiatric diagnoses were consistent with the current version of the Diagnostic and Statistical Manual.<br><br><u>Diagnoses clinically fit the corresponding assessments or evaluations</u><br>Psychiatric diagnoses were consistent with the information contained in the psychiatric evaluations.<br><br>Medical diagnoses were more variable. A significant concern was the stratification of diagnosis of pneumonia, pneumonitis, and bronchitis, and especially aspiration pneumonia. As reported in Section L1, diagnosis of aspiration pneumonia should be considered because many individuals with intellectual disability have known risk factors for aspiration pneumonia, and do not present with typical signs and symptoms of pneumonia. This is especially a concern when individuals have recurrent pneumonia and when individuals have dysphagia. For example, Individual #66 was fed by enteric tube, and experienced a total of 16 episodes of pneumonia since 2/27/2009. The Facility determined that three episodes were related to aspiration and 13 episodes were secondary to other causes then aspiration. There was no clinical evidence provided, or observed on site by the Monitoring Team, that would lead to the exclusion of aspiration pneumonia for the 13 episodes of pneumonia reported as "other causes" then aspiration. Furthermore, the Individual had significant underlying conditions that would contribute to aspiration pneumonia, rather then non-aspiration related pneumonia.<br><br>For individuals who experienced status epilepticus, all included an accurate diagnosis for the seizure disorder.<br><br>In some cases, a diagnosis may have been accurate based on the assessments done, but additional assessments would have been appropriate and useful to identify etiology or to confirm the diagnosis. For example:<br>• Individual #243 was diagnosed with dementia, Alzheimer's type"; the psychiatric assessment did not document a neurological examination, or psychomotor activity; and did not include review of clinical diagnostics, such as imaging studies, specific laboratory evaluation, or psychometric testing to aid in the diagnosis of Alzheimer's dementia. This was particularly relevant as the individual was reported to have change in physical function, specifically increased tone in the upper extremities that limited normal range of motion and a loss of ability to grasp/hold objects in the hand, as well as possible spinal issues that were not examined until the Medical Director assessed reflexes during the compliance visit and ordered additional diagnostic examination.<br>• There was continued and significant improvement with the diagnosis of low bone density. Nonetheless, one out of five samples (20%) demonstrated documented evidence that the medical provider fully assessed the individual for | |

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| | | potential secondary causes of low bone density. | |
| 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. | <u>Timeliness of Implementation</u><br>The Facility had procedures to audit timeliness of some types of treatments and interventions but did not have proactive procedures to ensure timeliness across all clinical disciplines. The Self-assessment reported data on timeliness for Positive Behavior Support Plans (PBSPs) and results of medical audits of timeliness of provider responses to quarterly drug regimen review recommendations, but it did not report other data on timeliness of treatments and interventions.<br><br>Timeliness of implementation continued to improve in many areas but remained variable. Examples of improvement included:<br>• Annual dental examinations, dental hygiene, and restorative treatments were provided timely.<br>• Improved timeliness of Human Rights Committee reviews permitted timely initiation of new psychotropic medications.<br>• As reported in Provision M3, acute care plans (ACPs) were implemented upon diagnosis of pressure wounds.<br>• As reported in Provision P2, direct OT/PT intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety.<br><br>Examples indicating a need for improvement included:<br>• As reported in Provision K4, progress noted for a sample of behavior intervention programs reflected several cases of worsening behavior or other problems without a timely response. For example:<br>o For Individual #734, progress notes reflected no replacement behavior training for at least three months, as well as missing target behavior data for the majority of days each month. Data collection problems continued for multiple months. In addition, missing treatment data were graphed as zero displays rather than as missing data, potentially adversely affecting treatment decisions.<br>Furthermore, 64% of the sample programs reviewed showed that either progress was evident, or the program was modified after three months.<br>• As reported in Provision K8, the Facility experienced difficulty in implementing PBSPs promptly after approval and consent were obtained. For 14 of 49 PBSPs completed since the previous site visit (29%), there was a delay of greater than 14 days between consent and implementation.<br>• As reported in Provision M3, Individual #587's g-tube soma site was assessed to have yellowish drainage with a foul odor on 6/30/13 (Sunday) and again on | Noncompliance |

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| | | 7/1/13. On 7/1/13 the nurse referred Individual to clinic for assessment of the yellowish drainage with foul odor from the stoma site. There was no documentation found that showed Individual #587 was seen in clinic. This continued until the Skin Integrity Nurse assessed the individual on 7/10/13, leading to a culture and initiation of treatment for MRSA on 7/15/13. The Monitoring Team was concerned by of the lack of the nursing staff and primary care provider's sense of urgency and prompt attention to the purulent stoma. The delay in treatment had the potential to worsen the stoma infection that could have led to a more systemic condition like sepsis and the spread of MRSA to other individuals.<br><br><u>Clinical Appropriateness</u><br>In general, treatments and interventions were based on assessments and were clinically appropriate. As noted in the examples below, this was not consistently the case, in part due to the need for more thorough assessments.<br>• As reported in Provision P2, the ISP or ISPA consistently described the supports based on the rationale provided in the therapy assessment.<br>• As reported in Provision K9, rationales for selection of proposed PBSP interventions were generally provided, although this was not as consistent as found in the sample reviewed at the last compliance visit. Some PBSPs were based on weak behavior assessments, so the Monitoring Team could not be sure they were clinically appropriate.<br>• As reported in Provision J3, progress was noted in the presentation of information and the overall use of medication. Medications were appropriate for the individual, and were well integrated into the overall treatment plan. However, as reported in Provision K5, although the PMR included several disciplines, and there were other examples of collaboration among psychiatric and behavior services staff, the behavior and psychiatric assessments for Individual #753 contained conflicting information and targeted the same behavior without rationale showing how the interventions complemented each other or addressed different aspects of the behaviors.<br>• As reported in Provision L1:<br>o There was significant improvement in treatment of low bone density.<br>o Provision L1 reported several examples in which treatment was not or may not have been clinically appropriate. In some of these cases, to ensure clinical appropriateness, further diagnostic assessment was needed. A specific case example was that of Individual #567; refer to Provision L1 for details.<br>o Provision L1 reported that medical providers did not regularly assess efficacy of prescribed supports and services for recurrent pneumonia. | |

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| | | Therefore, it could not be clear that treatment and interventions remained appropriate. For example, for Individual #305, there was a specific plan for aspiration pneumonia; however, did not address potential underlying medical causes of aspiration pneumonia, and there was no documentation in the annual medical assessment documenting the medical providers review of the efficacy of all prescribed supports and services to help mitigate aspiration pneumonia. | |
| 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><br>DSSLC Policy CMGMT 03 Integration of Clinical Services includes requirements related to the use of clinical indicators, including a section specifically titled "Clinical Indicators." The policy covers important aspects of the use of clinical indicators. Requirements include:<br>• The Medical Director will ensure clinical guidelines; protocols and selected indicators are in accordance with current generally accepted professional standards of care. Selected indicators will be presented for review during the QA/QI Council and PNMC."<br>• Clinical indicators will be established in integrated health care plans (IHCPs).<br>• Systemic "clinical indicators will be used by QAQI, PNMC regularly and others as needed to make center-wide changes and to assess effectiveness of actions."<br>• Clinical indicators will assess quality of care structures such as staffing of the infirmary, activities that constitute health care, and outcomes that follow care.<br>• Treatments and interventions should be modified in response to clinical indicators. "When clinical indicator data suggest unacceptable results, the current treatment plan will be altered(.)"<br><br><u>Use of Clinical Indicators for Systemic Improvement</u><br>The Facility provided a table of QA key/clinical indicators that included many indicators of the efficacy of treatment and interventions. The table also included the months they were to be reviewed, the person responsible for the data and analysis, and the executive staff responsible for related CAPs and initiatives. Review of QA/QI Council and PHMC minutes did not verify that all indicators were reviewed as indicated in the table (but the table did not indicate who was to do the reviews). For example, decubiti were to be reviewed monthly, but data were not included in the QA/QI Council documents for November 2013, December 2013, or January 2014.<br><br>The Facility also provided the following documents:<br>• List, by condition, of any standardized clinical indicators routinely used to assess progress or status of individuals with chronic healthcare conditions<br>• Risk Action Plan and Clinical Indicators/Data Considerations | Noncompliance |

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| | | At least regarding aspiration and respiratory risks, these two documents were identical. Both had a section for each risk on the IRRF for "Clinical Indicators/Data"; it was not clear whether the IDTs were to select indicators for areas of enhanced risk for individuals or whether this was to be used in another way (such as in an IHCP, annual medical summary, monthly QIDP review, or some other tracking system). The indicators included some that could be used for individual care, or aggregated for system improvement purposes, or both. Examples included (among others for the same risks, and for other risks):<br>• For the risk of choking, "# of choking incidents/dates" and "# incidents fool/liquid stealing"<br>• For the risk of aspiration, "# dx of aspiration pneumonia," #/type of specific triggers noted each month—emesis, coughing with struggle, red/watery eyes, wheezing," and "# shifts DSPs report sleepiness/lethargy"<br>• For the risk of respiratory compromise, "# dx of pneumonia" and "#daily O2 SATs below XX%"<br>• For the risk of skin integrity, "@ incidents/stage of pressure ulcer(s)," "Braden scale," and "# injuries to skin by location/severity<br><br>This provides a good list of examples, including some reviewed monthly or quarterly by the QA/QI Council (see below for listing of indicators reviewed at the last three meetings).<br><br><u>QA/QI Council Review of Trends in Clinical Indicators:</u> Section Leads reported quarterly on each section. In many cases, most of the information provided related to compliance on monitoring or audit tools. However, clinical indicators were routinely reviewed for some Sections. These were generally global indicators that would be useful to indicate trends for which further breakdown of information would be helpful.<br><br>In the documents for the 11/19/13 meeting, these indicators included:<br>• Number of hospitalizations<br>• Number of bowel obstruction diagnoses<br>• Number of deaths<br>• Number of all infections<br>• Number of all pneumonias<br>• Number of aspiration pneumonia infections<br><br>In the documents for the 12/17/13 meeting, these indicators included:<br>• Number of deaths<br>• Number of all infections | |

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| | | In the documents for the 1/14/14 meeting, these indicators included:<br>• Number of aspiration pneumonia infections<br>• Number of all infections<br>• Number of hospitalizations<br>• Number of deaths<br>• Number of individuals prescribed polypharmacy, broken down by number of psychotropic medications and separately for intraclass polypharmacy<br>• Number of uses of STAT medications other than for constipation<br><br>Some clinical indicator graphs did not provide adequate information to be useful. For example:<br>• Ratings of oral hygiene gave percentages of good and poor oral hygiene but did not give an idea of the size of the sample; differences from month to month might be affected if there were small sample sizes.<br><br><u>PNMC Review of Trends in Clinical Indicators:</u> 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. Review of PNMC minutes indicated PNMC routinely reviewed trends. Among the clinical indicators that continued to be reviewed by the PNMC on a monthly basis were:<br>• Hospitalizations<br>• ER visits<br>• Deaths<br>• Skin Integrity<br>• Enteral Nutrition<br>• Aspiration Pneumonia<br>• Pneumonia<br>• Falls<br>• Diabetes Management Report<br>• Individuals followed by PNMT and the PNMT's level of involvement<br>• UTIs<br>• Pseudomonas<br><br>PNMC had routinely reviewed trends in clinical indicators related to pneumonia and respiratory infections, hospitalization, skin integrity, mobility status, infections, and falls; minutes reflected instances in which information was specific to certain units and apartments, which led to localized actions. Minutes also indicated review and discussion when there were concerns indicated by data. For example, in the minutes for 1/3/13, | |

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| | | there was discussion because of a rise in skin integrity data (evidently in decubiti) at the hospital; actions that had been taken were discussed.<br><br>The monthly PNMC review would provide more timely data than the quarterly QA/QI Council review. Neither provides a broad enough set of indicators to be a comprehensive review likely to identify emerging concerns quickly enough to take preventive action. The Facility did not provide documentation of other review of clinical indicators addressing facility-wide status on a regular basis.<br><br><u>Need for Indicators for Proactive Decisions on Treatment</u><br>One common feature of all the above reviews is that the clinical indicators involve adverse outcomes. There is little review of general health status indicators that could provide information useful for individual care and could then be aggregated for system-wide review of health status. Clinical indicators should not only include measures of the occurrence of healthcare problems such as new instances of pneumonia or hospitalizations, but should also include measures that could lead to proactive treatment decisions prior to such instances and, at the same time, indicate trends in health status facility-wide, such as measures of HbA1c in individuals with diabetes (note that the Facility did provide a graph of HbA1c, so it is possible such indicators are reviewed, but this was not evident in other documentation).<br><br><u>Review at Integrated Morning Report:</u> The IMR agenda included certain reports that were provided periodically (weekly, every other week, or every third week). The minutes reviewed by the Monitoring Team included a report by the Pharmacy that reported clinical indicators. Attached to the minutes of the IMR meeting of 12/31/13 was an email from the Pharmacy Director (note that this was the day scheduled in the IMR agenda for a Pharmacy report). This email described the status of seizure medication usage. It reported an increase in total seizure medication usage, in seizure medication polypharmacy, and in prescribing of Dilantin. It noted that this information and information from a meeting with the consultant neurologist was shared with prescribers, and actions to improve communication to the neurologist were planned. An attachment provided data on the use of seizure medications at various times between November 2010 and December 2013, providing not only numbers of individuals but also—a positive finding--percentage of the population or of individuals prescribed seizure medications at those times. Review of these data by the Monitoring Team indicated there was some increase in numbers of individuals prescribed polypharmacy although percentages did not reflect the increases; further review found the percentages in the December 2013 column were inaccurate. The evaluation of the data by Pharmacy was accurate; for future reports, the percentages should be corrected. This email and attached data provided an example of the use of a clinical indicator to assess the status of health care and to identify and address an emerging issue. | |

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| | | Assessment of Assessments<br>The Assessment of Assessments quality review included, in the Supplement, the following question: "Are appropriate Clinical indicators established for the diagnoses?" This question could be coded by diagnosis in the "Yes," "No," or "NA" column. For Individual #699, four diagnoses were coded Yes, and two diagnoses were coded No. Although 10 diagnosis codes were available, none were coded NA. As the graphs reported total percentages of compliance for the PCPs, the Monitoring Team could not determine what percent of audited records showed that clinical indicators were addressed; furthermore, there was no way for the Monitoring Team to assess the adequacy and appropriateness of the clinical indicators that had been selected. Therefore, the Monitoring Team cannot comment on the effectiveness of this audit tool n improving the identification and consideration of clinical indicator data for care of individuals.<br><br>Use of clinical indicators by the Physical and Nutritional Management Team (PNMT)<br>As reported in Provision O2, the PNMT addressed clinical indicators in planning and implementing supports and services for individuals.<br>• Five of five (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.<br>• Five of five (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 minutes.<br><br>Conclusion<br>The use of clinical indicators to determine efficacy of treatments and interventions continued to expand; there remains a need to ensure review of clinical indicators is routinely done for common and serious chronic conditions. At the same time, as reported in Provision H3, there remained cases in which treatments and interventions were not assessed for efficacy or in which decisions on treatment were not based on data on clinical indicators. To achieve substantial compliance, the Facility must track (especially for individual and, as selected, for system-wide review) indicators of health status that can be used for proactive decision-making, and must ensure decisions are made based on the indicators. | |
| H5 | Commencing within six months of the Effective Date hereof and with | 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 | Noncompliance |

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| | full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals. | responsibility to the clinical discipline lead for identifying the level of oversight required and indicates oversight may occur at the departmental level or by the QAQI Council.<br><br>The Facility had continued to use or had established several systems to monitor the health status of individuals, including the following:<br>• Clinical indicators, as reported in Provision H4<br>• 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.<br>• Review by the QA/QI Council of information from the Quality Assurance (QA) Plan that included clinical indicators the Facility monitored to assess the status of health care facility-wide. Please refer to Section E for detailed information.<br><br>The Self-assessment provided information from trended outcome data presented at the QA/QI Council and Physical Nutritional Management Committee (PNMC). It noted:<br>• Downward trends have occurred in incidence of pneumonia (with a brief increase in August and September followed by decline), aspiration pneumonia, infections, falls, and deaths. However, as reported in Section L, the data for aspiration pneumonia were questionable as total pneumonias plus respiratory illnesses had not decreased during 2013, and there is great difficulty in accurately determining which of these might have been related to aspiration.<br>• Increase in skin breakdown prior to the last compliance visit was addressed, and there has been a decrease.<br>• An increase in hospitalizations was addressed by a corrective action plan (CAP) completed by PNMC.<br>• An upward trend occurred in hospitalizations for constipation/bowel obstruction (to a total of three hospitalizations, still a small number for a population of this acuity). A CAP was developed.<br><br>The Facility also had a process for Providers Meetings. The Monitoring Team reviewed documents DSSLC provided from Providers Meetings. None of the three meetings included review or discussion regarding systemic clinical indicators. This meeting could provide an opportunity for medical services staff to discuss the status of medical care at the Facility and to identify areas of improvement that might lead to improved healthcare and individual health status.<br><br>Examples of use of, and lack of use of, clinical indicators included the following:<br>• Of a sample of 12 individual records for individuals determined to be at risk, four (33%) included the clinical indicators to be monitored and the frequency of | |

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| | | monitoring. This compares to the 43% compliance rate noted in the last report by the Monitoring Team.<br>• As reported in Provision P2, for four of five individuals' records (80%) 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 for the most part were clearly included as part of the OT/PT plan of service.<br>• The Facility had a Physical and Nutritional Management Committee (PNMC) that focused on systems issues related to physical and nutritional management as well as other clinical care issues such as falls and incidence of pneumonia. The PNMC routinely reviewed trends in clinical indicators related to pneumonia and respiratory infections, hospitalization, skin integrity, mobility status, infections, and falls; minutes reflected instances in which information was specific to certain units and apartments, which led to localized actions. At a meeting observed by the Monitoring Team, the PNMC review several clinical indicators in detail, 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, Infections, Aspiration Pneumonia, and Pneumonia. This provided a management level review of selected clinical indicators.<br>• Thirteen of 13 individuals' records (100%) 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. However, zero of three trigger sheets reviewed by the Monitoring Team (0%) were completed correctly.<br><br><u>Monthly review of progress</u>:<br>As reported in Provision F2d, beginning with ISP annual planning meetings held in October 2013, the Facility required the QIDP to make an overall monthly review and evaluation of progress rather than a quarterly review. QA/QI data, obtained from the QA/QI Report, dated November 19, 2013, indicated the overall Facility compliance for the Monthly Review Audit had dropped dramatically from 87% in August, 2013 to 5% in both October and November.<br><br>The Monitoring Team reviewed a sample of ten recent ISPs and found that the Facility continued to experience difficulties in the implementation of QIDP Monthly Reviews. Some reviews were absent, in some cases several reviews had the same information repeated each month, reviews provided little evaluation as to progress or need for revision even when data were present, and, in some instances, several reviews were | |

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| | | dated the same day.<br><br>The Facility reported piloting a new process, the QIDP clinical indicator review. The Facility provided a sample list of clinical indicators for QIDP clinical indicator review. The indicators were for Individual #355. This was part of a process being piloted to assist QIDPs in ensuring their reviews addressed data relevant to the ISP. The format provided included a set of tables and graphs (blank for this sample), each set being for one indicator. Indicators for this individual covered many areas of clinical services. Some, such as injuries, could be outcomes of a number of environmental conditions, healthcare, and other clinical treatment. Some, such as community outings and community tours, reflected non-clinical components of the ISP. Some, such as choking, aspiration, and gastrointestinal were clearly meant to cover all the risk areas of the IRRF. It appeared that the format would lend itself to having the IDT select specific goal areas and indicators, including all needed to cover data gathered to determine status of ISP action plans as well as health status.<br><br>The Facility had other processes to monitor health status of individuals.<br>• 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.<br>• The Integrated Morning Report provided an opportunity each day for communication of changes in health status, as reported in Provision G1.<br><br>As noted in the last report, the Facility is approaching substantial compliance with this provision. That reported stated that an area for improvement remains ensuring monitoring is done regularly and documents progress or regression based on data and other information; this continues to need to be done consistently. | |
| 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. | DSSLC Policy CMGMT 03 Integration of Clinical Services includes a section on modifying treatments and interventions in response to clinical indicators. It requires altering a current treatment plan when clinical indicator data suggest unacceptable results. Evidence that this was done include additional assessments and diagnostics, modified therapeutic regiments, revised risk ratings, and change of status integrated health care plans.<br><br>An example in which this was done is described in Section M and in Provision V4. At a Change of Status meeting for Individual #567, data on clinical indicators were presented, including lab levels at specific dates. Decisions were made about additional consultations and about a criterion for hospitalization based on hemoglobin level, which was to begin to be checked weekly. | Noncompliance |

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| | | An example also is described in Provision O2. In 12 of the 12 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.<br><br>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.<br><br>Provision R3 describes variability in modifying treatments and interventions in response to clinical indicators. For a sample of three individuals receiving direct communication interventions, recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress for all three (100%). For individuals receiving indirect speech services, documentation did not consistently contain information regarding whether the individual showed progress with goals or objectives.<br><br>Furthermore, as reported in Provision O7, although clinical indicators of status of physical and nutritional status were established in Integrated Health Care Plans (IHCPs), review of these indicators was inconsistent, as reported in Provision O7. Therefore, indicators were not used to identify when changes in interventions and Physical and Nutritional Management Plans (PNMPs) were needed. This was true even though effectiveness of PNMPs was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QIDP 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.<br><br>As reported in Provision K4, progress notes for five of 14 behavior intervention programs (36%) were noted to reflect worsening behavior or other problems without a timely response from the program author or IDT. It was particularly concerning that the treatment monitoring and adjustment process involved slow response to behavior changes, as well as limited efforts to correct inadequate data collection and errors in data graphs. Examples where treatment decisions could have been adversely affected included the following.<br>• For Individual #54, aggression increased for three months. Progress notes did not reflect an effort to review the efficacy of the behavior intervention or explore reasons for the demonstrated increase in behavior. | |

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| | | • Replacement behavior rates dropped to zero for Individual # 506 for two months while target behaviors increased. The progress note author described data collection efforts as "incredibly" poor, but data collection problems continued for multiple months.<br><br>Thus, modification of treatments and interventions in response to clinical indicators was variable. In some cases, this was done effectively and timely. In other cases, clinical indicators were available and were tracked, but they were not reviewed and assessed for need for revision of treatment or did not result in revisions. In other cases, clinical indicators were not tracked. | |
| H7 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H. | A draft DADS state policy addressed provisions G and H together. Although this policy had been initiated in November 2010, it had not yet been completed and implemented. The Provision Action Information provided by the Facility for Section H reported that the Medical Director and others reviewed "the new State Office policy draft of 'Minimum Common Elements of Clinical Care' and provided feedback to the State Office."<br><br>As reported in Provisions G1 and H4, DSSLC Policy CMGMT 03 Integration of Clinical Services guided the activities required in Sections G and H. The policy had been revised since the last compliance visit. Revisions involved responding to changes in statewide processes for assessments and primarily involved changes in names. The system and structure remained as reported in the last compliance report. 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 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."<br><br>DADS and DSSLC policies on the Integrated Support Plan included requirements for completion of assessments.<br><br>As reported above, several requirements of completing comprehensive assessments, and of using clinical indicators to make timely decisions on individual care and healthcare system improvements, while continuing to improve, were not fully implemented. | Noncompliance |

| SECTION I: At-Risk Individuals | |
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| Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. Section I Presentation Book (undated)<br>4. DADS Policy 006.1 At Risk Individuals 12/7/12<br>5. DSSLC Policy CMGMT -14 At Risk Individuals 1/15/13<br>6. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 10/4/13)<br>7. DSSLC Policy CC-04 Physical and Nutritional Management Committee (10/1/2013)<br>8. Record reviews:<br>a. Sample O.1: Individuals #170, #187, #209, #211, #243, #305, #392, #402, #414, #463, #499, and #689<br>b. Sample O.2: Individuals #170, #305, #499, #581, and #689<br>c. Sample O.3: Individuals #170, #187, #211, #243, #252, #305, #392, and #499<br>9. Record reviews for Individuals #305, #243, #211, #414, #463, #666, #251, #457, #24, #336, #425, and #519,(sample selected for data analysis)<br>10. Integrated Risk Rating Form and Risk Action Plan for Individuals #666, #519, #425, #608, #457, #509, #119, #541, #326, #461, #24, and #204<br>11. Individual Support Plans (ISPs) for all sampled individuals<br>12. Completed Physical Nutritional Management Plans (PNMPs) for all sampled individuals<br>13. Tools used to monitor implementation of PNM procedures and plans<br>14. List of Top 10 individuals causing injury to peers<br>15. List of Top 10 injured individuals.<br>16. List of individuals supported with bedrails<br>17. List of individuals injured from bedrails<br>**People Interviewed:**<br>1. Nancy Condon, Facility Director<br>2. Dora Tillis, Assistant Director of Programs<br>3. Paula Horn PT- Director of Habilitation Therapies (HT)<br>4. Eight DCPs (Cedar Falls, Eastfield, Timberhill and Garden Ridge)<br>**Meetings Attended/Observations:**<br>1. Physical and Nutritional Management Team (PNMT) 1/14/14<br>2. Physical and Nutritional Management Committee (PNMC) 1/16/14<br>3. Mealtimes and Transitions- Garden Ridge, Cedar Falls, Timberhill, and Eastfield<br>4. QA/QI Council 1/14/14<br>5. Change of Status meeting for Individual #567 (1/16/14)<br>6. ISPs for Individuals #228, #567, and #791 |
| | **Facility Self-Assessment:** |

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| | 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.<br><br>For Section I, in conducting its self-assessment, the Facility:<br>▪ 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:<br>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.<br>o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews.<br>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.<br>o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results.<br>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).<br>o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools.<br>▪ Used other relevant data sources and/or key indicators/outcome measures. For example, databases that showed trends in key clinical areas such as multiple diagnoses of aspiration pneumonia, skin breakdown, hospitalizations, and infectious diseases.<br>▪ Generally presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:<br>o Presented findings based on specific, measurable indicators.<br>o Measured the quality as well as presence of items.<br>o Did not distinguish data collected by the QA Department versus the program/discipline.<br><br>The Facility rated itself as noncompliant with the three provisions of Section I. This was consistent with the Monitoring Team's findings. 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 consistent and reliable results.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>▪ Actions were reported as complete or in process. Of the 29 action steps reported in the Action Plan 21 (72%) were reported as completed. |

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| | ▪ The Facility data identified areas of need/improvement primarily related to additional staff training and continued implementation of the at-risk policy.<br>▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. |
| | **Summary of Monitor's Assessment:**<br>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.<br><br>The Facility had initiated a Facility specific policy (CM 14) addressing its At Risk system.<br><br>The Facility continued to have a very active Physical and Nutritional Management Committee. It was evident to the Monitoring Team that the work of this committee was substantive and oriented to decision-making. The committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this Provision of the SA.<br><br>The Monitoring Team observed two ISP meetings held during the week of the review. Participation by relevant staff and use of clinical data in reviewing risk was improved from that noted at the last review.<br><br>Interdisciplinary clinical coordination continued to improve from that noted in previous reports.<br><br>While 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.<br><br>Many of the compliance scores reported in Provision I.2 and I.3 had improved from that reported in the last report by the Monitoring Team but need further improvement to reach an acceptable level. |

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| 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 previous 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 most areas monitored and reviewed by the Facility continued to improve. | Noncompliance |

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| | | A primary means for IDT identification of risks for individuals, and for establishing plans to address risks, is the Integrated Risk Review Form (IRRF) process. This is completed as part of the annual ISP planning meeting and revised as needed through Change of Status meetings and ISP Addendums (ISPAs). As reported in Provision M5, there was wide variation from unit to unit and within the IDTs in the formats used for IRRFs, 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 IRRF processes. The IDTs need to continue 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. The IDTs need to ensure that all relevant clinical indicators are considered when developing risk ratings, as well as including clinical indicators to be measured within plans for risk ratings.<br><br>The Facility continued to have a very active Physical and Nutritional Management 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 continued 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.<br><br>The IDT used the Risk Level Guidelines established in State policy for assessing and determining risk levels. The Monitoring Team observed three ISP meetings held during the week of the review to assess IDT considerations related to risk. Staff present at the ISPs were the actual staff who worked with the individual, and it appeared all staff needed at the ISP meeting were in attendance; however, for the ISP for Individual #228 the behavior health specialist left before discussion of behavioral health and the speech pathologist came to the meeting late and left early. The individual was present at all three meetings. One other meeting observed by the Monitoring Team was an IDT meeting to consider change in status and the Individuals medical condition precluded attendance. The use of clinical data in determining risk levels at each meeting was variable. For some risks, clinical data was available and used. For others, clinical data | |

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| | | was not available. Because of this it was sometimes difficult to determine if assigned risk levels were appropriate. For example, for both Individual #228 and #567 the IDT was not aware of the reason for a specific medication and did not attempt to get clarification, which could impact risk assignment levels. Additionally, for these two individuals the clinical discussion that did occur was very subjective as the IDT did not have specific information about health issues and symptoms that presumably would impact risk level determinations. Finally, team disagreements regarding risk levels were not always appropriately resolved. For example, for Individual #228 one team member brought up the question about the possible impact a history of thyroid issues might have on the Individual's weight issues. This was not acknowledged by other team members and consequently received no discussion.<br><br>In two of three meetings the ISP facilitator was unable to keep the team discussion on risk focused. This was the case for Individuals #228 and #567.<br><br>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. For example, in one out of five cases (20%) pursuant to Section L of the SA, the quarterly drug regimen review (QDRR) documented risks associated with the use of the benzodiazepine; however, review of associated IRRFs indicated that zero out of five examples (0%) commented on risks associated with benzodiazepine. The Monitoring Team suggests it is important to comment on specific risks associated with the use of benzodiazepines. Paradoxical agitation, cognitive decline, and fall risk are all important risks that should be clearly understood by the IDT, delineated on the QDRR, and considered in developing the IRRF.<br><br>As reported in Provision L1, there were concerns about regular assessment and medical action plans for individuals with recurrent pneumonia, including the criteria used to determine diagnosis of aspiration pneumonia. This could lead to underestimating the risk of aspiration pneumonia.<br><br>As reported in Provision O.2, identification of PNM risk had improved significantly from that observed at the last review. 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 remaining individuals did not have PNMPs and 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).<br>The risk assessment process in place at the Facility was not always able to operate | |

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| | | efficiently or with an adequate clinical foundation because of staff shortages. A Physical and Nutritional Management Team (PNMT) no longer existed that consisted of the appropriate members. The PNMT was missing a core physical therapist (PT) and the registered dietitian (RD) did not consistently attend the PNMT Core Meetings.<br>DSSLC continued to show improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. Issues identified by the Monitoring Team (and reported more fully in Provision O.2) included:<br>• Eleven of 12 individuals in Sample O.1 (92%) 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).<br>• One of five (20%) 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.<br><br>The Facility reported that through its QA process it had reviewed trended outcome data related to risk which was presented and reviewed at QA/QI Council meetings and meetings of the PNMC for the following areas:<br>• Skin Breakdown – after increase and action noted during past review, the Facility reported incidents had decreased.<br>• Hospitalizations – the Facility noted hospitalizations had increased and a CAP was completed by the PNMC.<br>• Pneumonias – the Facility noted an overall downward trend following increases in August and September. Note, however, the discussion in Section L regarding changes in classification of pneumonia and respiratory conditions, which may have affected this trend.<br>• Aspiration Pneumonias – the Facility noted an overall and continued downward trend. As noted above, this trend may have been affected by changes in classification of pneumonia.<br>• All Infections - the Facility noted an overall and continued downward trend.<br>• Hospitalizations for Constipation/Bowel Obstruction – the Facility noted an upward trend with three hospitalizations for this reason since the last visit. The hospitalization CAP addressed this trend.<br>• Falls – the Facility noted a slight downward trend and the PNMC was working to decrease this even more.<br>• Deaths – the Facility noted there had been three deaths since the last monitor's visit and this represented a downward trend; however, deaths that occurred just prior to, and during this review, reversed this trend. | |

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| | | While the Facility had an assessment and management system that was in many areas improving and was for the most part identifying individuals whose health or well-being was at risk, the system needs to continue to mature. The system for regular risk screening and assessment 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 78% which was less than the 83% reported in its self-assessment six months earlier.<br><br>The Monitoring Team selected 12 records to review to assess compliance with this provision. These were for Individuals #305, #243, #211, #414, #463, #666, #251, #457, #24, #336, #425, and #519.<br><br>For the 12 records reviewed, the most recent risk assessment for these 12 individuals reported a change in status in five cases. These were for Individuals #305, #243, #211, #414, and #463. In five (100%) the assessment process started within five days.<br><br>Two of the 12 Individuals were new admissions, and initial risk assessments were done within the timeframe prescribed in policy.<br><br>The remaining five Individuals had recent risk assessments which did not indicate a change in status.<br><br>Based on a review of nursing risk assessment records of a sample of six of these individuals (Individuals #457, #24, #336, #425, #519, and #666), five (83%) included an adequate nursing assessment to assist the team in developing an appropriate plan. The exception was for Individual #666. The compliance rate for this metric was reported as 100% in the last review. Refer to Section M of this report for additional information.<br><br>Based on a review of PNMT records of a sample of five of these individuals (Individuals #305, #243, #211, #414, and #463) for whom assessments had been completed to address the individuals' at risk conditions, three (60%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. This was attributable, in part, to the fact that the Physical Nutritional Management Team (PNMT) was missing a core physical therapist (PT) and the registered dietitian (RD) did not consistently attend the PNMT Core Meetings. The compliance rate for this metric was reported as 100% in the last review. Refer to Section O of this report for additional information.<br><br>Based on a review of risk records of two individuals (Individuals #666 and #251) with | Noncompliance |

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| | | challenging behavior and polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, both (100%) included a psychiatric assessment to assist the team in developing an appropriate plan. The compliance rate for this metric was reported as 100% in the last review. Refer to Section J of this report for additional information.<br><br>Based on this review this Provision was not in substantial 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. | For the 12 Individuals discussed in Provision I.2, based on a review of 12 records for individuals determined to be at risk there was documentation that the Facility:<br>• Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in eight (67%) cases. This was not the case for Individuals #243, #211, #666, and #251. This was an improvement from the 47% compliance rate noted in the last report by the Monitoring Team.<br>• Implemented a plan that met the needs identified by the IDT assessment in eight (67%) cases. This was not the case for Individuals #24, #425, #243, and #211. This was slightly less than the 71% compliance rate noted in the last report by the Monitoring Team.<br>• Included preventative interventions in the plan to minimize the condition of risk in nine (75%) cases. This was not the case for Individuals #666. #243, and #211. This was nearly the same as the 76% compliance rate noted in the last report by the Monitoring Team.<br>• When the risk to the individual warranted (five cases), the Facility took immediate action in each (100%). This was the case for Individuals #305, #243, #211, #414, and #463. The compliance rate for this metric reported in the last review was also 100%.<br>• Integrated the plans into the ISPs in 10 (83%) cases. This was not the case for Individuals #243 and #211. This was an improvement from the 41% compliance rate noted in the last report by the Monitoring Team.<br>• In nine (75%), the risk plans showed adequate integration among all of the appropriate disciplines, as dictated by the individual's needs. This was not the case for Individuals #666, #243, and #211. This was an improvement from the 65% compliance rate noted in the last report by the Monitoring Team.<br>• In eight (67%), appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. This was not the case for Individuals #24, #336, #425, and #366. This was an improvement from the 47% compliance rate noted in the last report by the Monitoring Team.<br>• Four (33%) included the clinical indicators to be monitored and the frequency of | Noncompliance |

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| | | monitoring. This was not the case for Individuals #457, #24, #666, #305, #243, #211, #414, and #463. This compares to the 43% compliance rate noted in the last report by the Monitoring Team.<br><br>While improvement in compliance ratings was noted in many areas this Provision remains out of compliance. | |

| SECTION J: Psychiatric Care and Services | |
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| Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment (12/27/13)<br>2. DSSLC Action Plan (AP) (12/05/13)<br>3. Facility Presentation Book for Section J for January 2014 visit<br>4. DADS Policy and Procedures 007.3 Psychiatry Services (05/01/2013)<br>5. DSSLC CMGMT 20 Use of Restraint (revised 06/01/2012)<br>6. Revised formats for Positive Behavior Support Plan (PBSP)<br>a. PBSP addendum with updated psychiatric information<br>b. PBSP with integrated psychiatric information<br>c. Psychological/Functional Assessment (PA/FA) and Positive Behavior Support Plan<br>d. Integrated Behavioral Health Assessment/PBSP<br>e. Integrated Behavioral Health Assessment (IBHA)<br>7. ISP Attendance sheets for psychiatry 08/01/13 – 11/30/13<br>8. Materials for ISP meetings on Individuals #228, #588, and #791 that took place during the week of the visit<br>9. Materials for Psychiatric Medication Review (PMR) meetings for Individuals #28, #278, #312, #363, #543, #684, #734, and #743, that took place during the week of the visit<br>10. Audits by Dr. Lagron, external psychiatrist, for Individuals #247, #461, and #702<br>11. Minutes of the Quality Assurance and Quality Improvement (QA/QI) meeting that took place during the week of the visit<br>12. Facility guidelines for what were considered routine vs. non-routine medical procedures.<br>13. 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<br>14. A list of any individuals for whom the psychiatric diagnoses have been revised since the last compliance visit, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s)<br>15. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Polypharmacy Review Committee (PRC), since the last compliance visit<br>16. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date<br>17. A tabulation that compared rates of Facility use of polypharmacy over time<br>18. A separate list of individuals for whom each of the following was prescribed:<br>a. Anticonvulsant medications used only for psychiatric indications<br>b. Anticonvulsant medications used only for neurological indications<br>c. Anticonvulsant medications used for both neurological and psychiatric indications<br>d. Lithium<br>e. Tricyclic antidepressants |

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| | f. Trazodone<br>g. Beta blockers being used as a psychotropic medication<br>h. Clozaril/Clozapine<br>i. Mellaril<br>j. Reglan<br>k. Anticholinergic medications<br>l. Benzodiazepines<br>19. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation (Total Intravenous Anesthesia [TIVA] or oral medication)<br>20. A list of all individuals screened for tardive dyskinesia with Dyskinesia Identification System Condensed User Scale manual (DISCUS) evaluations<br>21. DISCUS forms done over the past year that were rated "5" or higher<br>22. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effects evaluations<br>23. A list of individuals diagnosed with tardive dyskinesia and the Active Problem Lists (APL) for each of those individuals<br>24. Reiss Screens (both data and scoring sheets) done since the last review<br>25. A list of all individuals whose scores matched or exceeded Reiss Screen cut-off values per instrument guidelines<br>26. Materials presented to the treating psychiatrists for Psychiatric Medication Review (PMR) clinics during the week of the visit, for Individuals #28, #278, #312, #363, #543, #684, #734, and #743<br>27. Sample J1: Case reviews for individuals considered by the Facility to be stable on their current psychotropic medication, individuals who have been prescribed new medications due to clinical difficulties, and individuals with various kinds of polypharmacy regimens (including some whose polypharmacy is being challenged.) These were Individuals #1, #204, #216, #230, #258, #278, #370, #388, #399, #410, #579, #630, #702, #764, and #791. Materials reviewed were:<br>a. Social History<br>b. Most recent Comprehensive Psychiatric Evaluation (Appendix B format if done)<br>c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review (PMR)<br>d. Most recent Positive Behavior Support Plan (PBSP) and Structural and Functional Behavioral Assessment<br>e. Most recent Individual Support Plan (ISP)<br>f. Most recent Annual Medical Summary<br>g. Most recent Active Problem List (APL)<br>h. All Psychiatric Medication Reviews for the past six months<br>i. All Monitoring of Side Effects Scale (MOSES) and dyskinesia identification system (DISCUS) Side Effects Screenings for the past six months<br>j. All Quarterly Drug Regimen Reviews (QDRR) for the past six months<br>k. Most recent Health Risk Assessment Rating tool and team meeting sheet<br>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)<br>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
p. Informed Consent (IC) for medications
q. Most recent Human Rights Committee (HRC) review of psychotropic medications

28. Sample J2: Episodes of medical and dental restraint for Individuals #22, #28, #82, #90, #134, #192, #169, #209, #313, #335, #359, #395, #412, #461, #492, #526, #557, #583, #742, #749, #661, and #79. 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, and evidence related to all steps of the Facility restraint review process including administrative and programmatic follow-up.
29. Sample J3: Psychotropic medications approved by the Behavior Support Committee (BSC) and the Human Rights Committee (HRC) during the last six months. The plans reviewed were Individuals #1 (Tegretol), #12 (Lamictal), #204 (Depakote and Tegretol), #305 (Klonopin), #463, (Zyprexa). #474 (Luvox), #606 (Buspar), #630 (Geodon), #451 (Depakote), #702 (Cymbalta), and #799 (Zyprexa).
30. Sample J4: IBHA documents for Individuals #12, #165, #257, #277, #280, #319, #321, #372, #397, #411, #459, #527, and #616. These were examples of the new assessment format provided by the Facility during the visit.
31. PMR reviews attended by the Monitoring Team during the visit: Individuals #28, #278, #312, #363, #543, #684, #734, and #743

**People Interviewed:**

1. Arifa Salam, MD, Lead Psychiatrist 01/14/14 and 01/16/14
2. Robert Harden, MD, Staff Psychiatrist 01/14/14
5. Randy Spence, BCBA, Director of Behavioral Services 01/15/14
6. Satyajit Satpathy, MD, Staff Psychiatrist 01/14/14
7. Ranganath Habbu, MD, Staff Psychiatrist 01/14/14
8. Trenton Berrie, BCBA, Lead for Section C 01/15/14

**Meeting Attended/Observations:**

1. PMR clinic with Dr. Salam, 04/15/14
2. PMR clinic with Dr. Harden, 01/14/14
3. PMR clinic with Dr. Satpathy, 01/14/14
4. PMR clinic with Dr. Habbu, 01/15/14
5. ISP meetings, Individuals #228, #588, and #791
6. Behavior Support Meeting, 01/15/14
7. Integrated Morning Report 01/15/14

**Facility Self-Assessment:**

The Facility submitted a Self-Assessment for Section J. In its Self-Assessment, for each provision, the

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| | 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 provided a self-rating stating why it believed compliance had been achieved.<br><br>The self-assessment rating relied to a large extent on the results of the record audit completed by the Psychiatry Department. Three tools were used. The first two were tools used by an external psychiatrist employed by the Facility to conduct the record reviews. The first tool was a Comprehensive Psychiatric Evaluation (CPE) Monitoring Tool provided by DADS. The tool inquired about each of the elements of the CPE. The second tool was a Modified Psychiatry Monitoring Tool. This addressed Provisions J2, J3, J4, J6, J7, J8, J9, J10, J11, J12, J13, J14, and J15. For each provision there were inquiries provided by DADS about items required by that provision. For many provisions there were also inquiries the Facility had added to respond to processes and documentation specific to the Facility. The external psychiatrist also provided hand written comments about his findings on the record review. This provided feedback to the treating psychiatrists. The third tool was a monthly tracking for Provisions J1, J7, J11, and J15. This addressed provisions for which the relevant information was best accessed through Facility databases and scheduling resources, rather than the contents of a particular record. Examples were the level of psychiatric staffing (J1) and whether meetings required by the Facility process had taken place (J11 and J15). Those items were better addressed by Facility psychiatry assistants. The Facility also benefited from data collected through the Facility's QA/QI department and its processes, including the ISP Participation Tool, the ISP Monitoring Tool, and the ISP Documentation Tool.<br><br>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.<br><br>The Facility indicated it continued to be in compliance with Provisions J1, J2, J5, J7, J11, J12 and J15. The Monitoring Team concurred. The Facility also indicated that it was newly in compliance with Provision J10 and the Monitoring Team concurred with that. The Facility did not indicate that it was in compliance with Provision J14, since it had identified a deficiency in its performance. However, the Monitoring Team learned the a process was already in place to remedy that deficiency and was able to find the Facility in Substantial Compliance for the provision on the basis of that process along with overall compliance with other requirements of that provision. The Monitoring Team will re-visit the resolution of the identified problem during the next visit. |

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| | **Summary of Monitor's Assessment:**<br>The Facility made progress in a number of areas. Concerns that had been identified during the previous visit were addressed, and that made it possible for two provisions to come into substantial compliance. There was also a focus on integrated behavioral care that culminated in the introduction of the IBHA at the end of the review period. The two provisions that came into status of substantial compliance were: Provisions J10 and J14.<br><br>Provision J10: 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. During the previous visit the Monitoring Team observed that good quality processes were in place and confirmed that there was adequate documentation of the process. However, the final stage in the Facility process was HRC review of new and annual review of medications for various elements, including the IDT's above-mentioned determination. For many medications, timely HRC reviews were not in place during the previous review period. During the current visit the Monitoring Team confirmed the continued presence of the identified processes, their documentation, and also their timely review by HRC. This allowed a finding of substantial compliance.<br><br>Provision J14: The provision required that the Facility provide appropriate steps for informed consent for psychotropic medications. At the time of the last visit the Monitoring Team reviewed newly implemented procedures to assure timely review of the consents by HRC. Those procedures were deemed adequate but were newly in place at that time. During the current visit the Monitoring Team confirmed adequate implementation of the new procedures during the review period. Additionally, during the review period the Facility reported that the internal QA identified a new problem – the individualized list of possible key side effects on the Medication Plans (MP) did not always match the list of side effects on the consent form. However, the Monitoring Team learned that a process was already in place to remedy that deficiency. Accordingly, the Monitoring Team was able to find the Facility in substantial compliance for the provision. The Monitoring Team will review the resolution of the identified problem during the next visit.<br><br>Provisions J1, J2, J5, J7, J11, J12 and J15 remained in substantial compliance.<br><br>In other areas:<br>• For Provisions J3: Progress was noted in the presentation of information and the overall use of medication. There need to be further improvement in the behavioral treatment program (during this review period, typically the PBSP) for key information relevant to psychiatry such as the information needed for monitoring of medication efficacy.<br>• For Provision J13: Progress has been made in the presentation of psychiatric symptom data that will support monitoring of medication treatment for efficacy, but the requirements of the Provision were not met during this review period.<br>• For Provision J4: In many cases needed plans to reduce the need for pretreatment sedation were not in place. The Facility presented plans to expand interventions to reduce the need for pre-treatment sedation, but those too were not yet in place. Medical monitoring for safety during medical restraint also needed improvement. |

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| | • For Provision J6: Gradual improvement in the quality of CPEs was noted, but required standards were not yet reached.<br>• For Provisions J8 and J9: Progress was noted. A new format for integrated behavioral health assessments was just introduced and it appears to be promising. |

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| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| J2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| J3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment. | <u>PBSP documentation</u><br>Psychotropic medications were given to 240 of 469 (51%) individuals who lived at the Facility. The key requirement of the provision was that such medications should not be used as a substitute for a treatment program. The key treatment plan document for behavioral health during the review period was the PBSP (in one case, a Psychiatric Support Plan, [PSP]).<br><br>To provide quality assurance the Facility had engaged the services of an external psychiatrist who had reviewed 20 records. As described in the Facility Self- Assessment, the external psychiatrist determined that 50% of the records reviewed had a current PBSP, defined as having been done within the past 12 months and containing up-to-date information on the diagnosis and medications.<br><br>The Monitoring Team reviewed the 15 records of Sample J1 for the presence of key elements in the PBSP/PSP. Findings were as follows:<br>• <u>Psychiatric Diagnosis:</u> PBSPs/PSP for 12 of 15 (80%) individuals contained the individual's diagnosis or diagnoses. In all cases it was in the DSM format. In all cases the cited diagnoses were consistent with the information contained in the psychiatric evaluations and the information was provided in the DSM format.<br>• <u>Identification of the problem and need for behavior supports:</u> This PBSP section | Noncompliance |

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| | | typically outlined the general problems the individual experienced and the interventions used to provide needed supports. The section was present for 11 of 15 (73%) individuals. In all those cases psychotropic medications were identified in the PBSC section as one of the needed supports.<br>• Psychiatric case formulations: These were present in 10 of 15 (67%) of the records. The formulations were copied from the CPEs that were written by the treating psychiatrists. For details see the discussion for Provision J6 that focused on CPEs.<br>• Differentiation of learned problem behaviors and psychiatric symptoms/behavioral characteristics: These were present in 8 of 15 (73%) of the records. 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. Overall, it appeared to the Monitoring Team that efforts continued to be made across the campus to clarify how psychiatric and psychological factors affected individuals, and the results informed the combined case formulation and joint treatment plans. However, Provision K5 reported one example of a behavioral and a psychiatric assessment for Individual #753 that included conflicting information about psychiatric services and described the same behaviors as targets of both psychiatric and behavior interventions.<br>• Monitoring for treatment efficacy: Data-based monitoring of medications for efficacy was a key element of psychiatric treatment. The monitoring required support from IDT behavior analysts and psychologists and key information was located in the PBSP. The Monitoring Team reviewed PBSPs for the presence of the three elements of the reporting used by the Facility. They were 1) psychiatric treatment "targets," 2) operational definitions of those behavioral targets, and 3) clarification of the rating of severity used by the Facility's ratings (typically, three ). These three elements were present in 8 of 15 (53%) of the cases.<br><br>As above, the current report necessarily relied on the PBSPs that were in place for the review period. At the time of the visit, however, the Monitoring Team learned that the Facility had started using a new format for behavioral healthcare reporting and that was the Integrated Behavioral Health Assessments (IBHA). The Facility reported that IBHAs will be developed for each individual and they will contain information key from behavioral and psychiatric information.<br><br>The new format contained sections on the key aspects of the individual's history, including<br>• History, including behavioral treatment history<br>• Current Status, including DSM diagnoses<br>• Current services, including psychiatric medication and behavioral treatments | |

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| | | • Psychiatric assessments, including the psychiatric case formulation. The template for the IBHA also included a table of the individual's psychiatric target symptoms which are the focus of medication treatment(s). The table is accompanied by operational definitions of those target symptoms and severity codes that are used on graphs providing symptom tracking over time<br>• Behavioral assessments, including tools that explore the etiology of learned challenging behaviors<br>• Integrated findings, including a section on the differentiation of learned behavior and psychiatric symptoms and an integrated case formulation<br>• Recommendations<br><br>The IBHA was typically followed by three appendices – Appendix A for psychotropic medications, Appendix B for the implementation procedures for the PBSP, and Appendix C for the PBSP itself (or in some cases, the Psychiatric Support Plan or PSP.<br><br>During the visit the Monitoring Team reviewed the new document in some detail with the Facility. For many items of information the IBHA will contain information that is already in current evaluations. Other areas are expanded or new, for example the integrated findings and recommendations. At the time of the visit the Monitoring Team also requested as many examples as possible of the incoming document. Thirteen examples were provided and they are Sample J4 for this report. They were examined after the completion of the visit and their examination confirmed the initial impressions that were shared with the Facility during the visit. Overall, the incoming format appeared very well organized. In particular, the organization of the document to include psychiatric formulations, then behavioral formulations, and finally integrated findings for both provided a natural flow to the presentation. The Monitoring Team found the new/expanded sections on integrated findings and combined recommendations have the potential to be particularly useful, since they contain the elements needed to guide integrated treatment. As described under Provisions J3, J13 and J9, the new format structures and organizes information needed for compliance on those provisions. In the case of the material reported on Provision J9, there had not previously been a place for that information. The preliminary review of Sample J4 indicates that it should provide information needed to bring Provision J9 into substantial compliance. These positive initial comments notwithstanding, the new IBHA is too new to be the basis for the current compliance determination, for this provision or others.<br><br><u>Appropriate use of medication:</u><br>During the visit the Monitoring Team attended eight PMRs including at least one PMR for each of the four psychiatrists (Sample J5). As was the case during previous visits, participation in the clinic appointment included nursing, QIDP, DSP, in some cases the guardian and the psychologist/behavior analyst. The presentation of materials was comprehensive and the psychiatrist typically followed up the presentation with | |

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| | | questions to explore further the material presented. The Monitoring Team was encouraged to see that the presentation of psychiatric and behavioral data was in parallel but separate. That was important, since tracking on the psychiatric medication needed to reflect psychiatric symptoms and the tracking of behavioral symptoms needed to reflect learned behavior. Examples of PMRs in which the presentation of data and discussion of that data were good were:<br>• Individual #684: There was a good data-based discussion about the efficacy of Trazodone, used for sleep.<br>• Individual #363: There was a good data-based discussion about the efficacy of an increase in the dose of Aricept and ratings for dementia, the target for Aricept treatment.<br><br>The Monitoring Team also attended the annual ISPs for Individuals #228, #588, and #791 that took place during the week of the visit. The ISP presentations by the psychiatrists included a review of the medication(s) given to each individual. The medications were appropriate for the individual, and were well integrated into the overall treatment plan.<br><br><u>Medications used for staff convenience</u><br>The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PMRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience.<br><br><u>Medications used for punishment</u><br>To determine whether this was 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.<br><br><u>Chemical Restraint</u><br>There was one episode of chemical restraint at the Facility during the review period. Relevant protocols were followed and psychiatry completed the post chemical restraint clinical review.<br><br><u>Monitoring Team's Compliance Rating</u><br>Progress was noted in the presentation of information and the overall use of medication. There needed to be further improvement in the behavioral treatment program (during this review period, typically the PBSP) for key information relevant to psychiatry such as the information needed for monitoring of medication efficacy. The introduction of the IBHA was a positive step, since it organized the information well. | |
| J4 | Commencing within six months of | <u>Use of Pre-treatment Sedation at the Facility</u> | Noncompliance |

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| | 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. | 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:<br><br>Routine Medical Procedures. The Facility provided a list of Medical procedures considered routine. These procedures are typically done without sedation for most people. They would include:<br>• Non–invasive diagnostic procedures such as stress tests and EKGs<br>• Phlebotomy<br>• Many imaging studies such as x-rays, Dexascan, ultrasound<br>• IVs and heparin locks<br>• Injections and immunizations<br><br>Non-Routine procedures – these procedures are frequently or always done with sedation or sedations are offered as needed/requested. The procedures would include:<br>• Invasive-diagnostic procedures, colonoscopy<br>• Most painful procedures, venipuncture, and arterial blood gases<br>• Procedures requiring no movement - MRI, mammograms if person has involuntary movement due to medical or psychiatric condition<br>• Mediports, etc<br>• Surgeries<br>• Inserting PICC lines<br><br>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:<br>• 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.<br>• Type of restraint ordered (including oral and iv sedation)<br>• 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.<br><br><u>Amount of use of pre-treatment sedation</u><br>The Facility provided the Monitoring Team with a list of all Medical and Dental restraints | |

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| | | from 08/01/2013 to 11/25/13 that listed 229 total restraints. The Facility also reported that between 08/01/2013 to 10/31/2013 pre-treatment sedation was used during 25 of 541 (4%) dental procedures. TIVA was used during 65 out of 541 (12%) dental procedures.<br><br><u>Monitoring for Safety during Medical Restraint</u><br>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.<br>The Monitoring Team reviewed a sample of 22 individuals who received pretreatment sedation procedures on specified dates (Sample J2). Selection of the sample is provided in Section C of this report. The review showed that in 18 of 22 instances of restraint (82%) the physician had ordered monitoring per Facility protocol or had indicated another monitoring schedule. The former was typically done for oral sedation and the latter for TIVA. The monitoring was completed as ordered in five of 22 (23%) instances of restraint. One source of difficulty was that while the physician orders and nursing protocol called for 24 hours of monitoring, the medical restraint monitoring form covered only 21 hours. That required supplementation of the medical restraint form with a progress note or other documentation to document the last set of vital signs. This was not always present.<br><br><u>Plan to reduce the need for pretreatment sedation</u><br>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 Action Plan 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 non-routine medical procedures.<br><br>The Monitoring Team reviewed the 22 individuals in Sample J2. These were individuals who received pretreatment sedation procedures. Six of 22 individuals (27%) had appropriate authorization (i.e. informed consent with HRC review) for the use of the pre-treatment sedation. None of the individuals had appropriately developed treatment or strategies to minimize or eliminate the need for pretreatment sedation.<br><br><u>Monitoring Team's compliance rating</u><br>The Monitoring Team noted improvement in 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 | |

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| | | 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. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| 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><br>At the time of the visit psychiatric services were provided for 240 of 469 individuals (51%) who lived at the Facility. At the time of the last visit all individuals who lived at the Facility at that time and who needed an evaluation had had received one. As described under Provision J7, each individual admitted to the Facility during the review period needed to have a CPE because they had a psychiatric diagnosis and/or took psychiatric medications. Each of those individuals had received a CPE soon after admission. Since the last visit there were two referrals to psychiatry for individuals who had experienced a change in their clinical status. They too had received CPEs. Current DADS policy for psychiatry requires annual updates of the CPEs. That has long been the practice at the Facility; the Monitoring Team reviewed the records of the 15 individuals in Sample J1. All (100%) had had CPE updates during the past 12 months.<br><br><u>Review of Completed Evaluations</u><br>Since the requirement to have CPEs in place has been met, the key remaining question is the quality of the Appendix B evaluations and their annual updates. To assist with that process the Monitoring Team had in the past suggested the Facility needed a review of CPEs and other key psychiatric information for their quality. The Facility responded to that recommendation and engaged a board certified external psychiatrist for about 4 hours per week for QA activities. A key part of his work is a review of Facility psychiatrists' work, with a focus on the areas that have been identified as needing improvement. The external psychiatrist reviewed 20 records for the past quarter and his findings were the basis of several responses provided in the Facility Self- Assessment. The Facility reported that overall quality of psychiatric assessments has improved, especially in the area of the description of psychiatric symptoms and establishment of diagnosis. Case formulations and treatment plans in the psychiatric assessment were assessed by the Facility as needing further improvement.<br><br><u>Review of CPEs for new admissions</u><br>The Monitoring Team reviewed the CPEs for the individuals admitted during the review | Noncompliance |

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| | | period and offered comments as follows:<br><br>Individual #251: The case formulation presented a substantive list of symptoms that support the diagnosis of autism. The consideration of rule-outs for mood disorders, psychosis and anxiety disorders was also helpful. The patient is currently treated with two atypicals. The presentation of the information about mild hyperprolactinemia explained the introduction of Abilify as a potential alternative to Risperidone. The report mentioned that the individual had a corpus callosotomy to help with his epilepsy. That procedure is often associated with neuropsychological deficits that can affect daily functioning. It would have been helpful to know whether the individual has had neuropsychological testing and any results. There was a discussion about the possibility that Keppra could worsen irritability. The individual remains on Keppra although the dose was decreased, and the questions that were posed about Keppra could apply to Topamax. That too should be discussed in terms of follow-up at the Facility, as part of the psychiatric treatment plan.<br><br>Individual #280: The evaluation was detailed and substantive. The descriptions of past treatment efforts provided what was needed for ongoing treatment. The diagnosis of autism and the diagnosis of bipolar disorder were justified on the basis of generally accepted standards for diagnosis. However, it would have been helpful to comment on whether the time criteria for duration of bipolar episodes appeared to have been met. The second paragraph of the case formulation provides the kind of thoughtful reflection on differential diagnosis – that the seizure disorder and hypothyroidism were considered and rejected as etiologies for the core behavioral disorder. The brief discussion of these matters in the formulation can be used as an example of the basic level of attention the Monitoring Team thinks is needed to the matter of synthesizing materials presented in the CPE.<br><br>Individual #459: The evaluation was sufficiently detailed and provided sufficient evidence for the diagnosed disorders. There was a nice differentiation of psychiatric and behavioral symptoms. The discussion of abnormal thyroid labs and plans for needed endocrine follow-up were helpful. The formulation was adequate. It would have been helpful to comment on the individual's denial of psychotic symptoms at the time of the mental status examination and from the writing it was not clear whether the individual's denial was for the time of the exam or whether past history was discussed as well. In this setting that was important to know and based on the report, the individual appeared to have the ability to reflect on past events.<br><br>Individual #666 - Given the citation in the History of Present Illness (HPI) of elevated scores from autism and the symptom of social isolation, it would have been helpful to discuss the reasons that autism was ruled out. The individual had elevated Reiss scores for psychosis and paranoia. The possible reasons for were not clear. It would have been | |

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| | | helpful to comment on that. Perhaps the diagnosis of intermittent explosive disorder will be necessary but in the setting of moderate intellectual disability, the psychiatrist should cite past functional assessments that could help understand whether and to what extent the response was disproportionate with the individual's ability level in mind (was one done at the other DADS facility?). If a functional assessment had not been done the psychiatrist should have cited the need for one as part of the psychiatric plan and perhaps hold off on a definitive diagnosis until the results can be reviewed.<br><br>Individual #800: Generally, the examination is too cursory to constitute the substantive CPE of record. Given the information presented, it is possible that needed information was simply not available at this early stage. If the evaluation was a preliminary assessment to be expanded later, that should have been stated. The evaluation cites hypothyroidism but relevant labs are not mentioned; since a mood disorder is considered, the endocrine disorder should have been discussed in the differential diagnosis as a potential contributing if not etiologic factor. The history and family history do raise the possibility of bipolar disorder, but the diagnostic criteria have not been met and the diagnosis cannot be justified. The family history cites hypermania. Perhaps that was typographical error and the intention was hypomania. Since sexual abuse was identified there should have been discussion of how and why that was reflected – or in this case not reflected in – the eventual diagnosis. In this case and others, a discussion of not only the diagnosis but also the differential diagnosis was needed.<br><br><u>General Impressions:</u><br>As detailed in previous reports good CPEs are a priority since they lay the groundwork for many subsequent clinical activities, and materials from the CPE are now central to key enduring documents, such as the IBHA.<br><br>There is no question that Facility psychiatrists have the ability to provide the level of comprehensiveness that is needed for CPEs. Yet the challenges at the Facility are somewhat unique compared to other DADS facilities. At DSSLC, CPEs have long been in place and in many cases there is a need to improve existing work, not to introduce CPEs de novo. In some ways this presents a particular set of challenges, especially for individuals who have lived at the Facility for many years. In those cases psychiatrists have to review records of individuals they know very well, and to revisit old records in order to bring them up to the required levels. There is much work to be done for a large number of individuals, yet that work must be accomplished to meet the required standards.<br><br>To provide feedback on the level of comprehensiveness that is needed, in the judgment of the Monitoring Team the evaluations for Individuals #280 and #459 were adequate, the evaluations for Individuals #251 and #666 were marginal, and the evaluation for | |

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| | | Individual #800 was insufficient.<br><br><u>Monitoring Team's Compliance Rating:</u><br>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 comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner. | <u>Reiss Screens for Individuals who lived at the Facility</u><br>At the time of the visit there were 469 individuals residing at the Facility. Two hundred forty individuals received ongoing support from the psychiatry clinic, and all of those individuals had psychiatric evaluations in place. All remaining individuals had been screened with between 12/01/12 and 03/31/13, as reported at the time of the last visit.<br><br><u>Admissions to the Facility since the Last Visit</u><br>Between 07/26/2013 and 12/09/2013 there were five admissions. These were Individuals #251, #280, #459, #666, and #800. All of the individuals were admitted with a psychiatric diagnosis or were taking psychiatric medications. Each of the individuals received a psychiatric evaluation soon after admission. In no case was the delay longer than 2 ½ weeks.<br><br><u>Reiss Screens for Recent Admissions</u><br>Since the individuals had psychiatric diagnoses and received psychiatric evaluations there was no need for a Reiss Screen for these individuals. Nonetheless Individuals #280 and #666 received Reiss Screens. 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. In each of the two cases the individuals scored positive on the screen, indicating the possible need for psychiatric services. That was a good demonstration of the integrity and validity of the testing process.<br><br><u>Reiss Screens for Change of Status Evaluations</u><br>In July 2013 the Facility put in place a process for evaluation of psychiatric services due to a change in behavioral status. The purpose of the procedure was to identify what was 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. There were two referrals to psychiatric services for individuals not receiving psychiatric treatment and a psychiatric assessment was completed. In each case the protocol was followed. | Substantial Compliance |

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| | | Monitoring Team's Compliance Rating<br>The Monitoring Team had previously confirmed that that Reiss Screens were in place for all individuals on campus who required them and that the administrations of the screen were done correctly. None of the individuals admitted during the review period needed a Reiss Screen since they had psychiatric diagnoses and all had CPEs soon after admission. An adequate procedure was in place for the use of the Reiss Screen during evaluations for a behavioral change of status.<br><br>The Monitoring Team found that the Facility has continued to meet the requirements of the provision and is found to be substantial compliance with the requirements of this provision. | |
| 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.<br><br>As outlined in previous reports, the Facility had many places in the clinical process where psychiatrists, psychologists, and other IDT members worked side-by-side to generate the combined assessments and case formulations required by this provision. Some of these were the PMR clinics, medical reports, and ISP meetings.<br><br>PMR clinics were the place where many of the day-to-day psychiatric functions took place. During the current visit the Monitoring Team observed PMR clinics to see integrated care functions. For reports on the observations, please review the descriptions under Provisions J3, J9, J10 and J13. As a general observation the Monitoring Team assessed during the current visit – as it has in the past - that there was good multidisciplinary participation in the PMR and, for the most part, good interdisciplinary examination of the relevant clinical issues. For enduring documentation, key elements of the day-to-day work of psychiatrists were captured in psychiatrists' annual updates to the CPE. The Monitoring Team's work report on the quality of their work is reported under Provision J6.<br><br>Enduring documentation for the overall behavioral health team required those providers to come together to provide a document that captures the essence of the behavioral treatment understanding and plan. At DSSLC the IBHA is now replacing the PBSP as the repository of integrated behavioral care, supported by good quality assessments from the behavioral disciplines. For more detailed discussion and review of current status, please see Sections J3, J9, and J13, as well as Section K.<br><br>The highest level of integrated care at the Facility was the ISP meeting, where the overall IDT came together with the individual and family. ISP meetings for Individuals #228, 588, and #791 took place during the week of the visit and the Monitoring Team attended | Noncompliance |

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| | | those meetings. For each individual the treating psychiatrist participated in the meeting, presented some of the information that had been prepared ahead, and was available to interact with IDT members, the Individual and the Individual's LAR. There too, the process was adequate.<br><br>For integrated care at the level of the IDT the Monitoring Team reviewed the ISP documents for the 15 individuals in Sample J1. The format in which behavioral treatment information is brought to the ISP has been via the writing of the behavioral health section in the IRRF document. To that end the Facility had expanded that section to provide side by side summaries of psychiatric and behavioral care. Such an expanded section was present in 13 of 15 (86%) of the ISPs reviewed. The quality varied. An example of a good work product was the IRRF statement for behavioral health for Individual #791. The IRFF provided a nice balance of a general understanding and specific guidance for the coming year. An example of an IRRF document that was less strong was the one written for Individual #399. It consisted largely of general checkboxes that contributed little to either the understanding or planning for the individual. In addition to the contribution to the IRRF, six of 15 ISPs (40%) also contained substantive psychiatric information under Section VII (Other Health Area) of the ISP. Typically, the section contained the psychiatric case formulation from the PSP or annual update of the PSP, along with details from the medication plans. Here too, the quality varied based on the quality of the medication plans (reviewed under provision J13) and case formulations (reviewed under J6). As the IBHA comes into place – implementation has just started – it is possible the IDTs will choose to cite from the IBHA in the ISP.<br><br><u>Monitoring Team's Compliance Rating:</u><br>There has been progress on this provision. Integrated care at the level of the behavioral team continues to improve, as have the gleanings of information from the behavioral team for use by the broader IDT, for example in the ISP. As described above, the behavioral contributions to the ISP are now more standardized and the information has been carefully selected to focus on key elements of behavioral health information that support the overall ISP. Nonetheless, the overall quality does need to continue to improve to provide what the SA requires. The Monitoring Team concurs with additional details outlined by the Facility in the Self-Assessment. | |
| 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, | <u>Psychiatry Participation in PBSP and other IDT activities</u><br>To meet the requirements of this provision, psychiatrists needed to be involved in the development of the treatment plan 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, Qualified Intellectual Disability Professional (QIDP), nurse case manager, and Direct Support Professional (DSP). At times, legally authorized representatives (LARs) or others also participated, | Noncompliance |

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| | 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. | either in person or via telephone contact. Primary Care Providers (PCPs) 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.<br><br>Treatment plans were developed after discussion and input from all IDT members to ensure that the interventions in place were the least intrusive and most positive to treat the behavioral or psychiatric condition. The IDT also determined during these meetings whether 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.<br><br>The particular requirements for Provision J9 were for assurances that the IDT:<br>• Had determined the least intrusive and most positive interventions to treat the psychiatric condition were used<br>• Had confirmed that medication treatment would also be accompanied by non-pharmacological support<br>• Had assessed whether the individual was best served though behavioral, pharmacological or other interventions, in combination or alone<br><br>The Monitoring Team reviewed the three required elements of the provision by examination of the PBSPs (or as outlined below, the current alternative to the PBSP) of the 15 individuals in Sample J1.<br><br><u>That the least intrusive and most positive interventions to treat the psychiatric condition were used</u><br>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. Thirteen of the 15 records reviewed (86%) contained the required determinations. Examples of cases that contained details descriptions of prior efforts to provide behavioral alternatives to medication were:<br>• Individual #204: "A full review of records was completed and information regarding previous (medication) interventions and their efficacy is lacking. Mellaril was discontinued in (date provided). Depakote was started on (date provided) for reports of aggression and fluctuation in sleep pattern. Depakote was discontinued on (date provided) due to significant daytime sedation along with the lack of convincing evidence of the diagnosis (Bipolar Disorder) at the time. (The Individual) is now prescribed Zyprexa and has been taking Zyprexa since (date provided). Previous behavioral supports included Posey mittens and seat belt in an effort to control his aggressive behavior. Historically, aggression | |

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| | | increased when (the individual) has not been prescribed an antipsychotic or has been on lower doses of antipsychotic medication."<br><br><u>Non- Restrictive Practices in current plan</u><br>Padded lawn chair on patio<br>Discrimination training<br>Verbal/physical prompting<br>Leisure time outside<br>Verbal praise<br>Choice of Mobility Options (i.e. wheelchair)<br>Non-contingent attention"<br><br>• Individual #216: "(The individual) has an Axis 1 mental health diagnosis of Major Depressive Disorder, Recurrent (296.30) The use of the antidepressant drug Effexor is necessary to address this disorder. The PST noted that on (date provided) Effexor was reduced by the consulting psychiatrist (named) to (dose provided). More recently (date provided) Effexor was increased (doses provided) due to an increase in symptoms of depression related to (the individual) receiving news of his mother passing away.<br><br>On (date provided) aggression to persons was discontinued from the program as the criterion was met for its removal. On (date in 2009) a major overhaul of the PBSP was made at (the Individual's) yearly planning meeting. The purpose of these changes was to make the PBSP a better fit for (the Individual's) behavior. In 2010, 2011, and 2012 it was decided to continue the current PBSP as it had been effective in preventing and managing (the Individual's) aggression."<br><br><u>Non-Restrictive Practices in current plan</u><br>Differential Reinforcement of Alternative Behavior<br>Physical Blocking<br>Antecedent Management Strategies<br><br>For other individuals, the description were more brief, but still adequate. For example:<br>• Individual #702: "Other restrictive measures used in the past have included restraint, time-out procedures, and restriction from her motorized wheelchair following unsafe driving or attempts to propel it into other people (dates provided)."<br><br><u>Non-restrictive Supports:</u><br>Redirection<br>Environmental engineering<br>Verbal, gestural, physical prompts | |

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| | | Differential Reinforcement of Alternative Behaviors<br>Differential Reinforcement of Other Behaviors.<br><br>The way that the requirement information was structured into the treatment program varied in a number of cases. Individual #230 had a Psychiatric Support Plan (PSP) rather than a PBSP. In this individual's case the information was contained in a section called "Non-pharmacological Treatment History." Similar formatting was present for Individual #410 for whom there was a Combined Psychological Assessment and PBSP. For Individual #791 the relevant section was called "Current and Recent Behavioral History." The program for Individual #258 was called Integrated Behavioral Health Assessment/PBSP and the relevant section was titled "Behavioral Treatment History."<br><br>Looking ahead, the Facility has opted to consolidate formatting into a single "Integrated Behavioral Health Assessment" that is discussed under Provision J3. Section 1c of that document is for "Behavioral Health History." That is a straightforward title and could provide the information needed for the requirements of Provision J9.<br><br><u>That medication treatment would also be accompanied by non-pharmacological support</u><br>All the PBSPs (or their equivalents) reviewed for individuals in Sample J1 were for individuals who received pharmacological support. For these individuals, information about non–pharmacological supports was provided in many places in the PBSP. A good place in the DSSLC records to find information about the roles of pharmacological non-pharmacological supports was the "Differentiation Between Learned Problem Behaviors and Psychiatric Symptom" section. Such a section was present in 10/15 (66%) of the records. For the individual who had a PSP rather than a PBSP, the PSP included a section about environmental supports (mostly related to daily living, interactions with others and her preferences). There was a section discussing past PBSPs and there was monitoring to assure that problems successfully addressed were not recurring.<br><br>Information about the place where details about both pharmacological and non-pharmacological supports were contained was the section on differentiation of learned behaviors and psychiatric symptoms. In the newly implemented Integrated Behavioral Health Assessment there is a "differentiation Between Learned Behavior and Psychiatric Symptoms" section. It is part of the "Integrated Care" section of the assessment.<br><br><u>Whether the individual was best served though behavioral, pharmacological or other interventions, in combination or alone</u><br>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 needs to clearly state which modalities of treatment – via a PBSP, | |

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| | | psychotropic medication, or perhaps something else such as a sensory integration program – are best suited to the individual and his/her needs. With the current PBSB there was no single place where such information was best placed. The Monitoring Team found that review of the 15 records in Sample J1 showed that the best place to find that information was in the psychiatrists' case formulation now included in the PBSP. For example, for Individual #579 the psychiatrist wrote "pharmacotherapy with Risperdal 2 mg BID to target symptoms of mood lability, irritability/impulsivity and agitation. Inderal 80 mg three times per day helps with anxiety….. PBSP implemented to minimize challenging behaviors." The shortcoming of relying on the psychiatrist for such statements is that the psychiatrist may not be in the best position to know the details of the psychological and other treatments, or the relevant non-psychiatric information may not be available when the psychiatrist is doing the CPE, such as at the time of admission.<br><br>During the current visit the Monitoring Team was informed about the incoming IBHA and reviewed the template for that assessment. The new format provided a clear flow of information and there were sections for a psychiatric case formulation (section Vb), a behavioral assessment (section Vc), integrated findings and integrated case formulation (section Vd) and finally, for recommendations (section XI). Since the recommendation section was located at the end of the assessment, it appeared to be an appropriate place to list treatments from all modalities. Six of 13 (46%) of the new assessments provided information on treatment recommendations from various modalities. They were the assessments for Individuals #165, #280, #319, #372, #397, and #411. A combination of such a listing of recommendations, accompanied by an explanation in the body of the assessment as to why the recommendation was made, would be one way to meet the requirements of this key part of Provision J9.<br><br><u>Monitoring Team's Compliance Rating</u><br>As outlined under Provision J2 and J3, and others, the quality of the IDT discussions in the PMR and elsewhere is good. Progress has been made toward integrated behavioral care, in part via the development of the IBHA format, as outlined above. That format has been in place for a very short time, and the documents reviewed for the current review period – primarily the records contained in Sample J1 – did not yet provide the information required by the SA. For now, the Facility remains in noncompliance 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 | <u>Policy and Procedure</u><br>DADS policy and procedure "Psychiatry Services" dated 05/01/2013 stated 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 | Substantial Compliance |

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| | physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. | 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."<br><br><u>Processes in place for Risk Benefit Assessment</u><br>The place where discussions about medication (including risk/benefit analyses) typically took place was the PMR. PMRs often took place on a monthly basis or quarterly basis. Interdisciplinary Team (IDT) participation in the clinics included the psychiatrist, Qualified Intellectual Disability Professional (QIDP), nurse case manager, psychologist and direct care professionals (DCPs). 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 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.<br><br><u>Quality of the Risk Benefit Assessment</u><br>During the visit, the Monitoring Team observed discussion about risk and benefit during eight PMRs, three ISP conferences, and the Integrated Morning Report.<br>• The quarterly PMR review for Individual #684 included a detailed discussion of current and past side effects of Trazodone, which had been newly introduced. Alternative treatments (medication and non-medication) were discussed, for example the question of whether Trazodone remained and was needed. The QDRR reviewed the two medications the individual took (Depakote as well as Trazodone), commented on possible drug- drug interactions (there were none) and also issues related to concomitant use of the two medications – including increased anticholinergic side effects. Risk of metabolic syndrome was reviewed. 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.<br>• In the PMR clinic for Individual #363 there was a good discussion of the risk of concomitant use of medications for dementia and olanzapine, the risk and benefits of continuing with the several cholinesterase inhibitors, and whether they were warranted given the advancing dementia.<br>• In the PMR for Individual #28 there was considerable discussion about the individual's poor health and the possible effect of her medication on sleep. | |

There was a detailed review of QDRR information that included review of labs and results of MOSES and DISCUS side effect screens.

Overall, the Monitoring Team observation during the visit confirmed that good quality processes were in place to review medication risk and benefit that included the typical point of service (the PMR), individual review (the ISP conference) and Facility-level review (the PRC).

<u>Documentation of Risk Benefit Assessment and Alternative Treatments for New Medications</u>
The Monitoring Team reviewed all 12 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 in (1) the most recent PMR note for IDT discussion, (2) the MP sections on rationale, alternative psychotropic medication treatments considered (and why) and in the section on adjunctive treatments in place or suggested, and (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 in documents provided? | Monitoring Team's assessment |
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| Psychiatric diagnosis for the medication | 12 of 12 (100%) | DSM diagnosis present in 12 of 12 (100%)of the medications |
| Rationale for the use of medication | 12 o f 12 (100%) | Reasonable rationale provided for 9 of 12 (75%) of the medications |
| Psychiatric target | 12 of 12 (100%) | Reasonable psychiatric |

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| symptoms for the treatment | | symptoms for treatment identified for 10 of 12 (83%) of the medications |
| Documentation of risk benefit discussion | 12 of 12 (100%) | Adequate presentation provided for 10 of 12 (83%) of the medications |
| Documentation of nurse case manger participation in IDT deliberations | 12 of 12 (100%) | Present for 12 of 12 (100%) of the medications |
| Documentation of participation of the PCP in IDT deliberations (typically via telephonic contact with the psychiatrist) | 12 of 12 (100%) | Documentation per signature on consent form |
| Documentation of participation of the psychiatrist in IDT deliberations | 12 of 12 (100%) | Documentation adequate for 12 of 12 (100%) of the medications |
| Documentation of specific medication side effects pertinent to the individual | 12 of 12 (100%) | Documentation adequate on 12 of 12 (100%) of medication plans, but see comments in discussion for provision J14 regarding differences between MP and consent. |
| Documentation of possible alternative treatments | 12 of 12 (100%) | Documentation adequate for 12 of 12 (100%) of the medications |

HRC Review of New Medications

Timely HRC review had not been in place during most of the previous review period and that was the main reason the provision was not found in substantial compliance at that time. In contrast, timely review by HRC was in place for all 12 new medications approved during this period. The Monitoring Team also reviewed the records of the 15 individuals in Sample J1. Thirteen of the 15 individuals (86%) had timely review of annual consent for ongoing (renewed) medications by HRC.

For more details, see discussion under provision J14.

Monitoring Team's Compliance Rating

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| | | 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. HRC reviewed medications (new and renewals) for various elements including the IDT's determination that the risks of the harmful effects of the mental illness were greater than the risks of possible medication side effects. | |
| 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 parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| J12 | Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly. | <u>Policy and Procedure:</u><br>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 the side effect screens 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.<br><br><u>Process in Place for Side Effect Screening</u><br>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. | Substantial Compliance |

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| | | 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 PRC.<br><br><u>Individual Case Reviews - MOSES and DISCUS Examinations</u><br>The Monitoring Team reviewed MOSES and DISCUS since the last visit for 15 individuals in Sample J1. The MOSES and DISCUS examinations were complete administrations of the tools and the forms provided to the Monitoring Team included all elements of the examinations, including the physician review sections. Typically, all sections of the examinations were completed.<br><br>Confirmation that MOSES examinations were done at least every six months was provided for 14 of 15 (93%) individuals and timely physician review was present for 13 of 15 (86%) individuals. A total of 35 administrations of MOSES for the 15 individuals in Sample J1 were provided to the Monitoring Team. The additional screens were typically done in response to changing clinical conditions such as a change in the dose of medication. In many but not all of the cases this was stated on the MOSES but in some cases IPNs and PMRs did not clarify the reason. It appeared to the Monitoring Team that on some homes MOSES examinations were administered quarterly on a routine basis rather than every six months. Quarterly DISCUS examinations were required only for individuals who took medications that put the individual at risk for tardive dyskinesia. Nine of the 15 (60%) individuals took such medications. A total of 21 DISCUS examinations were reviewed for those individuals. Most were routine quarterly reviews and several were done in response to changing clinical conditions.<br><br>Combining MOSES and DISCUS data, 13 of the 15 (86%) individuals had the examinations required for the medication they took, which contained all required elements, showed the presence of physician comments, and were completed and signed in a timely manner.<br><br>Note also that a different sample was reviewed for Provision N5, including 12 MOSES and 10 DISCUS assessments provided for Individuals #703, #90, #666, #248, and #185.<br>• In 12 out of 12 MOSES assessments (100%), there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool.<br>• In nine out of 10 DISCUS assessments (90%), there was evidence that the prescriber signed, dated, and c completed the physician component of the assessment tool. | |

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| | | Monitoring for Metabolic Syndrome<br>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, and 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 observed PMRs for eight individuals (Sample J5) and noted that metabolic syndrome screening was reviewed in 7 of 8 (87.5%) PMRs. Metabolic syndrome monitoring was also a focus of the PRC.<br><br>DISCUS Monitoring for Individuals taking Metoclopramide<br>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 was listed as one of the medications that required DISCUS evaluations every three months. There were 29 individuals at the Facility who took metoclopramide. Facility nursing tracking sheets showed that DISCUS screenings were provided 29 of 29 (100%) of those individuals every three months. None rated positive for dyskinesia.<br><br>Facility level review of Individuals who had Tardive Dyskinesia<br>The Monitoring Team was provided with a list of individuals who were tracked for tardive dyskinesia due to a diagnosis of dyskinesia or suspected dyskinesia. These were Individuals #20, #47, #117, #204, #285, #131, #311, #363, #399, #444, #486, #531, #702, #743, and #774. Active Problem Lists (APLs) were provided for 12 of 15 (80%) of the individuals. All individuals who were diagnosed with dyskinesia had that diagnosis on the APL. 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. PRC meeting minutes confirmed that the review of all individuals who had dyskinesia was done as part of the work of the PRC.<br><br>Training for Administration of the MOSES and DISCUS side effect screens:<br>The Monitoring Team reviewed the training for side effects screen (MOSES and DISCUS). Training continued as described in previous reports and was based on the *Applied Tardive Dyskinesia Monitoring Manual (3rd ed), Kalachnik, J and Slaw, K (2007)* provided by DADS. Training was facilitated by videotape and additional written materials prepared by the author. The Monitoring Team confirmed that nurse case managers | |

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| | | attended annual re-training on the administration of the side effects tools. Sign-in sheets from the Nurse Education Department were reviewed for both initial trainings courses for new employees (four trainings during the year) and annual retraining sessions for ongoing employees. Twenty nine of 31 (94%) nurse case managers participated in the annual refresher training for MOSES and DISCUS administration.<br><br><u>Monitoring Team compliance ratings:</u><br>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. PRC provided Facility level review for tardive dyskinesia and metabolic screening monitoring.<br><br>The Facility provided side effect screens 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 | <u>Facility Procedure</u><br>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. The sections of the MP remained:<br>• Name of the medication<br>• Psychiatric Diagnosis<br>• Rationale for Treatment<br>• Psychiatric Target Symptoms<br>• Monitoring for Efficacy (by whom, where and how often)<br>• Timeline for Expected Results<br>• Risk/Benefit Assessment<br>• Treatment Alternatives<br><br>While the MPs listed the psychiatric target symptoms for the medication, that alone was not sufficient to enable data-based monitoring of psychiatric symptoms. Since the selection of target symptoms was individualized, there was also a need for operational | Noncompliance |

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| | 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. | definitions for the symptoms, so that psychiatrists and other clinicians could be clear on what was rated. Similarly, since data-based reports on symptoms at the Facility were often based on Likert-like scales of severity and/or frequency of symptoms, psychiatrists and other clinicians needed to know what was meant by particular numerical ratings. For that reason, a full listing of psychiatric targets, operational definitions, and severity criteria was a necessary part of the behavioral treatment program (PBSP, PSP, IBHA or other).<br><br>PMRs for individuals #28, #278, #312, #363, #543, #684, #734, and #743 were observed by the Monitoring Team. Presentation of psychiatric data had improved, compared to previous visits. For eight of eight (100%) individuals, psychiatric and behavioral data were presented separately, and the psychiatric data graphs were presented on the same (or adjacent) pages. That was positive because it allowed a comparison of changes in medication dose and targeted psychiatric symptoms. More detailed comments on the graphing of data are included under Section K10.<br><br>The Monitoring Team also noted that data on operational definitions of symptoms and clarification of severity ratings were part of the template for the incoming IBHAs. However, IBHAs were not yet in place for individuals seen in PMRs.<br><br>During previous visits, the Facility pointed out that medications needed to be initiated in a variety of clinical situations. Sometimes medication trials were elective and in those situations it was often wise to have all three elements of medication tracking in place prior to starting the medication, so that baseline ratings of symptoms could be obtained. Such baseline measures are very helpful for subsequent determination of medication efficacy and the Monitoring Team encourages the Facility to use them more often. In such cases there was time to revise the treatment program to include changes in the details of medication tracking. At other times, clinical circumstances required that medications to be initiated without such baseline measures or other delay. When that was the case it was important to be able to start the medication on the basis of the MP and the existing behavioral treatment plan (without revision). During the July 2013 visit, the Facility proposed that in such cases needed treatment plan revisions could then be done within 30 days. The Monitoring Team agreed (see Provision J14 for the last visit).<br><br>During the current visit there was additional discussion of this matter, since the Facility wanted clarification about which changes in the psychiatric information required a revision of the behavioral treatment program. The Facility pointed out that the behavioral programs were reviewed annually and for some changes that took place during the year, appropriate updates could be made at the time of annual review. The Facility noted unneeded revisions of programs could reduce staff availability for other important priorities, including direct care to individuals. All also agreed that it was important for treatment plans to be updated when there was new or updated | |

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| | | information or information relevant to tracking medication for treatment efficacy (targets, operational criteria, severity criteria). The psychiatrists needed to have that information to support their daily work on behalf of individuals. Behavioral plan information about other changes in other psychiatric parameters (for example diagnoses) could be updated at the time of the annual update of the PBSP/IBHA as long as APLs were kept up to date<br><br><u>Monitoring Team's Compliance Rating</u><br>Progress was made in the presentation of psychiatric symptom data that will support monitoring of medication treatment for efficacy, but the requirements of the Provision were not met during this review period. | |
| J14 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks. | <u>Facility Policy</u><br>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 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."<br><br><u>Consent Form in Place at the Facility</u><br>The consent form currently in use at the Facility provided the following information:<br>• Diagnosis<br>• Medication for approval, medication dose, and route of administration<br>• FDA recommended dose range<br>• Pertinent side effects (discussed with guardian/director)<br><br>The consent form had boxes for signature/date of the prescribing physician (which in all cases was the psychiatrist) and for the psychiatrist to document the date/time of the discussion between the psychiatrist, primary care physician, and 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.<br><br>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: | Substantial Compliance |

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| | | • A description of any benefits to be expected<br>• Disclosure of any appropriate alternative procedures that might be advantageous to the person served as well as the potential risks and benefits associated with those alternatives<br>• Possible adverse side effects/risk of the prescribed medication, per drug effect monographs provided<br><br><u>Medication Plans provided to LARs</u><br>LARs were provided with a copy of the MP that contained considerable information about the medication including information on:<br>• Name of the medication<br>• Psychiatric Diagnosis<br>• Rationale for treatment<br>• Target psychiatric symptoms<br>• Monitoring for Efficacy (by whom, where and how often)<br>• Timeline for expected results<br>• Risk/Benefit Assessment<br>• Treatment Alternatives<br><br><u>HRC Review of Consent</u><br>The Facility used a revised (effective 3/22/13) form for HRC review of psychotropic medication. The form provided check boxes for<br>• Psychiatric case formulation and treatment plan<br>• Psychotropic medication plan<br>• Psychotropic medication consent form<br>• Most recent PBSP<br><br>These boxes identified the information that was provided to HRC for medication review and approval.<br><br><u>Monitoring Team Review</u><br>To assess compliance during the overall review period the Monitoring Team requested all non-emergency psychotropic medications started since the last visit. That was Sample J3 and consisted of 12 medications for 11 individuals. Presentation of information about the medication continued to improve and the MPs all used the template described above and contained information for each of the eight fields listed above. Review of the consent forms showed that in all cases informed consent was obtained from the LAR. At times when telephonic consent was necessary, the consent was witnessed and written consent was subsequently obtained. HRC reviews were timely, in a large majority of the cases within one week. HRC review confirmed the presence of the four elements listed immediately above. The Monitoring Team also | |

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| | | reviewed the medication consents for annual renewal of medication and HRC approval for the 15 individuals in Sample J1.<br><br>The Monitoring Team also reviewed medication consents and HRC review for the 15 individuals in Sample J1. Consents were provided for all psychotropic medications and timely HRC review was provided for 13 of 15 (86%) individuals.<br><br>Overall, the Monitoring Team reviewed consents for 50 medications, taken by the 26 individuals in Samples J1 and J3.<br><br>In the Facility Self-Assessment the Facility reported that internal QA had identified a new problem – in their review of new medications presented to the HRC during the review period the individualized list of possible key side effects on the MP did not always match the list of side effects on the consent form. The lists did not conflict but the purpose of listing side effects that are most pertinent is to highlight key information for that individual in the discussion about consent. It was potentially confusing for the guardians to receive one set of information in the MP and another in the consent discussion itself. For that reason, the Facility did not self-rate for Substantial Compliance on the provision. However, in the conversation with the Facility the Monitoring Team also learned that a process was already in place to remedy the identified deficiency. First, psychiatrists had already been reminded of the need for consistency between the two documents. Also, a case by case review of medication proposals was started just prior to the visit, to make sure the two documents concurred. This was done by a manual review done by the psychiatry assistants for each medication, prior to the medication being presented to HRC. The Monitoring Team determined that an adequate remedy was in place for the problem self-identified by the Facility itself via its QA processes, and made its compliance rating with that in mind.<br><br><u>Monitoring Team's Compliance Rating</u><br>During the previous visit the Monitoring Team noted that timely HRC review was the only matter standing in the way of substantial compliance on this provision. Such reviews were routine throughout the review period. A process was in place to make sure that the same list of side effects deemed most relevant would appear on both the consent form and the medication. The Monitoring Team reviewed 50 medications for 26 individuals, found no other difficulties, and the Provision was found to be in substantial compliance. The Monitoring Team will review the matter of the side effect listing again during the next visit, to confirm that the problem does not recur. | |
| J15 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |

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| | 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. | | |

| SECTION K: Psychological Care and Services | |
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| Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment (12/27/2013)<br>2. DSSLC Action Plan (12/5/2013)<br>3. DSSLC Presentation Book for Section K (1/24/2014)<br>4. Documents that were frequently reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), structural and functional behavior assessments (SFBAs), Integrated Behavior Health Assessments (IBHAs), 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.<br>• The review of data monitoring practices in Provision K.4 included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>• The review of Psychological Assessment reports in Provision K.5 included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>• The review of SFAs concerning assessment of behavior in Provision K.5 included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>• The review of SFAs in the context of the integration of mental illness and behavior assessment in Provision K.5 included Individuals #4, #54, #311, #353, #506, #617, #637, #638, #690, #734, #753, and #774.<br>• The review of psychological testing, including adaptive skills and intelligence, in Provision K.6 included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>• The review of psychological testing and evaluation reports for individuals admitted to the Facility since the previous site visit presented in Provision K.7 included Individuals #280, #459, and #666.<br>• The review of PBSPs in Provision K.9 included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>• The review of data graphs in Provision K.10 included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>**People Interviewed:**<br>1. Randy Spence, MS – Director of Behavior Services<br>2. Katy Acheson, MS, BCBA – Contract Psychologist<br>3. Ira Adams, PhD – Behavior Health Specialist V<br>4. Trent Berrie, MS, BCBA – Behavior Analyst I<br>5. Candy Mathers, MS – Behavior Health Specialist V<br>6. Janet Waggoner, MS, LPC, BCBA – Behavior Analyst I<br>7. Criquette Tassin, MS – Behavior Health Specialist V<br>8. Laura Dittlinger-Harper, BCBA - Consultant |

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| | 9. Approximately 25 direct support professionals in the following residences: 502b, 502c, 502d, 505c, 506c, 507a, 508a, 508c, 512d, 515a, 515b, 515c, 515d, 522a, 522a, 524a, 524d, 527b, and 528b.<br>**Meeting Attended/Observations:**<br>1. ISP meeting for Individual #791<br>2. Observations were conducted in the following residences: 502b, 502c, 502d, 505c, 506c, 507a, 508a, 508c, 512d, 515a, 515b, 515c, 515d, 522a, 522a, 524a, 524d, 527b, and 528b. |
| | **Facility Self-Assessment:**<br>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.7, K.8, K.11, 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, K.8, and K.11. Regarding Provision K.5, the Monitoring Team found weaknesses in the assessment of behavior and symptoms of mental illness, as well as the assessment of intellectual ability and adaptive skills. In Provision K.7, the Monitoring Team found a lack of assessments for half of new admissions, as well as inconsistencies between tracking data and assessment reports submitted by the Facility. 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.<br><br>For Section K, in conducting its self-assessment:<br>▪ The Facility reported the use of monitoring/auditing tools for some items; for example, an external consultant recorded reviews of psychological assessments on the form entitled Settlement Agreement Cross-Referenced with ICF/MR Standards. For reviews of other requirements, the specific tools were not identified. Instead, the Facility did report the materials or procedures that were reviewed, often with substantial detail.<br>▪ 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,<br>▪ 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.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>▪ Actions were reported as Complete, In Process, and Not Started. No particular patterns were noted in the status of elements.<br>▪ 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. |

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| | **Summary of Monitor's Assessment:**<br>Observations, interviews, and record reviews were conducted on-site at DSSLC from 1/13/2014 through 1/17/2014. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, a pervasive decline was noted across several provisions. This was most evident in relation to behavior assessments and intervention, the identification of behavioral aspects of mental illness, data collection and presentation, and the ability to effectively monitor treatment outcomes and exercise evidence-based practices in formulation of treatment decisions.<br><br>The Behavioral Health Services department at Denton State Supported Living Center employs several well-qualified professionals, contracts with other recognized experts for additional services, and maintains a professional relationship with the University of North Texas for behavior analytic training and services. It was therefore unexpected to find reduced performance to the extent and degree noted during the current site visit. As discussed later in this report, there were several examples of sophisticated assessments and interventions in the documents reviewed. It was therefore possible that the lower ratings constituted an aberration in the sample. As it was the Facility rather than the Monitoring Team that selected the sample, however, it would be more likely to find the sample skewed toward the positive rather than the negative. It was also possible that the lower ratings reflected weaknesses in the monitoring, QA, or peer review procedures. Even if the sample reflected an aberration, it would still be difficult to explain the weaknesses noted without accepting that the review process had also declined. This would be of additional concern in that the Monitoring Team agreed to an abbreviated review of the peer review procedures due to previous ratings of substantial compliance.<br><br>Regardless of the causative factors for the decline, it is recommended that the Facility exercise the necessary diligence regarding the current circumstances. It would be beneficial for the Facility, as well as for individuals served at the Facility, to carry out a comprehensive review in all areas related to the noted weaknesses.<br><br>Specific examples of limitations or a lack of progress included the following.<br>• A sizable portion of behavior assessments and intervention plans were developed by staff who were not BCBAs.<br>• Slightly less than two thirds of data graphs were adequate for the development of treatment decisions.<br>• According to the Facility tracking data, 29% of individuals living at the Facility had not been provided a psychological assessment report in the past year.<br>• In comparison with the preceding site visit, behavioral assessments that reflected adequate functional assessment practices dropped by approximately 30%.<br>• Approximately only one third of behavior assessments used evidence-based practices to differentiate between learned and biologically based behaviors where such practices were necessary.<br>• Behavioral progress notes frequently described poor quality data, missing data collection forms, and poor cooperation by staff in the collection of target behavior and replacement behavior data. |

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| | Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved.<br>• All Behavior Health Service staff either were BCBAs or were engaged in board certification prerequisites.<br>• The Facility continued to employ a BCBA as director of the Behavior Health Services department.<br>• The Facility continued to provide exemplary counseling services for those individuals identified as potentially benefiting from such services.<br>• All reviewed behavior intervention plans included staff instructions that met readability expectations. |

<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>During the current site visit, Facility records regarding Behavior Support Department staff were reviewed. These records reflected that 12 of 20 staff (60%) were board certified as a behavior analyst. Of the remaining 8 staff, 8 (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.<br><br>
<table>
<tr><td></td><td>3/2010</td><td>7/2013</td><td>1/2014</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>24%</td><td>58%</td><td>60%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>23%</td><td>100%</td><td>40%</td></tr>
<tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>50%</td><td>100%</td><td>100%</td></tr>
</table>
<br>DSSLC maintained a process for auditing credentials of those staff members who possess board certification in applied behavior analysis.<br><br>During the current site visit, the Monitoring Team used a sample of 14 individuals for the review of behavior intervention plans to determine the percentage of plans completed by a BCBA. The Facility selected the sample from individuals with recent ISPs. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774. Based upon the information provided from the review, seven of 14 behavior intervention plans (50%) were completed by a BCBA.<br><br>The Facility demonstrated continued progress in hiring or developing BCBAs. As not all staff were BCBAs, and only a portion of behavior intervention plans were completed by a BCBA, it was determined that the Facility was not yet in compliance with the Settlement Agreement for this provision.</td><td>Noncompliance</td></tr>
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| K2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| K3 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| K4 | Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed. | <u>Historical Perspective</u><br>Considerable deficits were noted in the collection of behavior data during the initial site visits. Staff reported, and observations and progress notes supported, that at times it was difficult to collect data as indicated in the PBSP.<br><br>In February of 2011, a new data collection system was implemented that used a standard form for recording data. This form was designed to accommodate frequency counts, as well as duration, interval and accuracy measures. In September 2011, observations and record reviews revealed substantial improvement, although substantial limitations continued.<br><br>During the April 2012 site visit, substantial changes had been recently introduced to the data presentation and progress note format, including changes to the graphing process, increased use of condition-change lines and annotations, and the integration of psychiatric target symptom tracking. Despite this progress, regression was noted in other data collection areas.<br><br>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.<br><br>In July 2013, it was noted that the Facility continued to make progress concerning data collection and presentation, but substantial compliance had not been achieved.<br><br><u>Current Site Visit</u> | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
During the current site visit, the Monitoring Team used a sample of 14 individuals for the review of data collection and treatment monitoring. The Facility selected the sample from individuals with recent ISPs. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br><br>
The table below reflects the results from the current site visit review regarding the collection and presentation of data.<br><br>
<table>
<tr><th></th><th>3/2010</th><th>7/2013</th><th>1/2014</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>100%</td><td>79%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>100%</td><td>71%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>71%</td><td>71%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>93%</td><td>93%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>60%</td><td>86%</td><td>64%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making</td><td>0%</td><td>86%</td><td>71%</td></tr>
</table>
<br>
The information obtained during the site visit reflected no improvement in any area and regression in four of six areas. Issues that contributed to the reduced ratings included the following.<br>
• Target behavior data for Individuals #208 and #690 were reported as monthly total frequency. In the data graphs, as well as comments by the program author, it was noted that the targeted behavior occurred in isolated outbursts during a small number of days each month. Other methods of collecting and presenting data, such as the number of days each month involving behavior displays or the interval between days with behavior displays, could have enhanced the treatment monitoring process.<br>
• In most graphs, a vertical line, sometimes called a condition change or phase change line was inserted to show when something had changed for the individual, usually a medication change or a revision to a behavior intervention. In some graphs, the vertical lines were drawn through the trend lines, the lines that run from one data point to another. In several other graphs, the trend line stopped prior to the condition change line and then restarted after the condition change line. Where there were few condition change lines on a graph, this introduced no substantial issues. Those graphs that included several condition change lines, however, often lacked meaningful trend lines and appeared to
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| # | Provision | Assessment of Status | Compliance |
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| | | consist of multiple isolated data points.<br><br>The availability and presentation of treatment data is only one aspect of the process of monitoring the benefit of intervention plans and psychotropic medications. It is also necessary to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary. | |

| | 3/2010 | 7/2013 | 1/2014 |
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| Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level | 0% | 100% | 100% |
| Review is conducted by a BCBA | 0% | 21% | 50% |
| Input from direct care staff is solicited and documented | 0% | 29% | 29% |
| Modifications to the PBSP reflect data-based decisions | 0% | 71% | 64% |
| Criteria for revision are included in the PBSP | 0% | 100% | 100% |
| Progress evident, or program modified in timely manner (3 Months) | 0% | 79% | 64% |

Based upon available data, it was determined that the Facility had maintained previous ratings in three areas, and had progressed in two areas. Regression, however, was noted in two additional areas. Noted weaknesses and concerns included the following.

- Despite improvement, the monthly review of treatment data and progress notes involved a BCBA in only seven of the 14 reviewed records (50%).
- Input from direct care staff was presented in progress notes for only four of the 14 records (29%).
- Modifications to the PBSP reflected data-based decisions in only nine of 14 records (64%).
- Progress notes for five of 14 behavior intervention programs (36%) were noted to reflect worsening behavior or other problems without a timely response from the program author or IDT.

It was particularly concerning that the treatment monitoring and adjustment process involved slow response to behavior changes, as well as limited efforts to correct inadequate data collection and errors in data graphs. Examples where treatment decisions could have been adversely affected included the following.

- For Individual #54, aggression increased for three months. Progress notes did not reflect an effort to review the efficacy of the behavior intervention or explore reasons for the demonstrated increase in behavior.

| # | Provision | Assessment of Status | Compliance |
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| | | • Replacement behavior rates dropped to zero for Individual # 506 for two months while target behaviors increased. The progress note author described data collection efforts as "incredibly" poor, but data collection problems continued for multiple months.<br>• For Individual #734, progress notes reflected no replacement behavior training for at least three months, as well as missing target behavior data for the majority of days each month. Data collection problems continued for multiple months. In addition, missing treatment data were graphed as zero displays rather than as missing data, potentially adversely affecting treatment decisions.<br><br>It should be noted that the Facility reported a new format for behavior assessment and intervention, developed and required by DADS, had been adopted shortly before the current site visit. The new format, called the Integrated Behavioral Health Assessment (IBHA), differed substantially from the previous format in terms of document organization, headings, and sections. The Facility indicated that through the use of additional subsections and appendices, attempts had been made to integrate all information from the previous format into the IBHA.<br><br>Only two IBHAs were included in the sample of 14 records selected by the Facility. Although insufficient for review purposes, these two IBHAs suggested that the transition to the new format was not easy. It was not evident that the new format allowed for a coherent presentation of the evidence-based process beginning with descriptive, structural and functional assessment and leading to an adequate behavior intervention. In addition, it was not evident that authors were prepared to develop assessments and plans in the IBHA format, as headings, tables, graphs and narratives often reflected errors in organization, margins and spacing. This led to further difficulties in reading and interpreting the information presented. Additional IBHAs will be reviewed at the next site visit.<br><br>Based upon the available information, it was evident that the Facility lacked the safeguards necessary to ensure that treatment data were recorded correctly and consistently. Furthermore, it was not clear that treatment decisions were evidence-based or that the Facility possessed the means to ensure that all individuals were provided with the necessary interventions. As a result, the Facility was found to have not met the criteria for substantial compliance. | |
| K5 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and | <u>Historical Perspective</u><br>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. | Noncompliance |

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>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. In July 2013, 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.<br><br><u>Current Site Visit</u><br>During the current site visit, the Monitoring Team selected a sample of 14 individuals for the review of psychological and behavior assessment. This sample included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br><br>
<table>
<tr><th></th><th>3/2010</th><th>7/2013</th><th>1/2014</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>100%</td><td>71%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>50%</td><td>71%</td></tr>
<tr><td>The Psychological Assessment contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>80%</td><td>14%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>9%</td><td>100%</td><td>71%</td></tr>
</table>
<br>Based upon the findings of the review, it was apparent that DSSLC had not maintained previous progress in ensuring that Psychological Evaluation reports contained the necessary test results. In the sample of 14 individuals, the following issues or weaknesses were noted.<br>
• Only two of 14 individuals (14%) had been provided with a current intellectual assessment. This reflected a decrease of 66% in comparison with the previous site visit.<br>
• Ten of 14 individuals (71%) had been provided with a current assessment of adaptive behavior. Although better than ratings regarding the intellectual assessments, this reflected a decrease of 29% in comparison with the previous site visit.</td><td></td></tr>
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| # | Provision | Assessment of Status | Compliance |
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| | | The Facility also provided global data regarding intellectual and adaptive skill assessments. A review of those data reflected the following issues.<br>• Thirty-eight of 494 individuals (8%) were reported to have an intellectual assessment.<br>• Data reflected that 468 individuals were provided with a formal assessment of adaptive skills. For 120 of those individuals (26%) the assessments were over one year old. For 152 of those individuals (31%) the associated report was either over one year old (n=120, 26%) or the assessment was less than a year old but there was no report (n=32, 5%).<br><br>In addition to providing intellectual and adaptive assessments, it is crucial to present those assessments in a manner that goes beyond the reiteration of scores and facilitates the identification of personal strengths and limitations. The Monitoring Team the same sample of 14 records presented above to determine the degree to which this was achieved. | |

| | 3/2010 | 7/2013 | 1/2014 |
|---|---|---|---|
| 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% | 80% | 14% |
| 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% | 100% | 71% |

Based upon information obtained from the Facility, it appeared that several limitations existed concerning Psychological Evaluation reports and the testing of individual abilities. Furthermore, the noted limitations reflected a substantial regression from previous achievements demonstrated by the Facility.

<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

| # | Provision | Assessment of Status | Compliance |
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| | | 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.<br><br><u>Historical Perspective</u><br>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. 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. In July 2013, although it was evident that the Facility continued to progress, it was noted that practices were not consistently implemented across the Facility.<br><br><u>Current Site Visit</u><br>During the current site visit, the Monitoring Team selected a sample of 14 individuals for the review of psychological and behavior assessment. This sample included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774. | |

| | 3/2010 | 7/2013 | 1/2014 |
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| Assessment or review of biological, physical, and medical status | 0% | 95% | 86% |
| Review of personal history | 0% | 95% | 86% |
| A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis | 0% | 95% | 64% |
| The process or tool utilizes both direct and indirect measures | 0% | 100% | 64% |
| Identification of setting events and motivating operations relevant to the undesired behavior | 0% | 95% | 64% |
| Identification of antecedents relevant to the undesired behavior | 0% | 95% | 64% |
| Identification of consequences relevant to the undesired behavior | 0% | 95% | 64% |

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| Identification of functions relevant to the undesired behavior | 0% | 95% | 57% |
| Summary statement identifying the variable or variables maintaining the target behavior | 0% | 100% | 64% |
| Identification of functionally equivalent replacement behaviors relevant to the undesired behavior | 0% | 100% | 57% |
| Identification of preferences and reinforcers | 0% | 100% | 71% |

Of the 14 behavior assessments reviewed, five (Individuals #353, #506, #565, #617, and #638, 36%) were outstanding examples of behavior assessment and the implementation of functional assessment procedures. An additional three assessments (21%) reflected very sound practices concerning the assessment of operant behaviors, but demonstrated weaknesses in relation to behaviors associated with mental illness. These findings suggested that the Facility was familiar with and possessed the ability to conduct adequate assessments of behavior. It was not evident, however, that the Facility was able to ensure that acceptable practices were implemented across the Facility. Examples of limited assessments are presented below.

- For Individual #311, the most recent behavior intervention reflected that the most recent assessment updates addressed only the development of operational definitions for behavioral analogs of mental illness. Prior to that, the most recent behavior assessment was completed in May 2012. There were no indications that the 2012 assessment had been reviewed for current validity.
- For Individual #637, the most recent behavior assessment report was dated 7/23/2013. Although data current at the time of that report were included, many of the actual assessments presented were one to three years old at the time of the report. In circumstances where an individual had experienced few changes, it might be possible to use older assessments. In the case of Individual #637, however, the report indicated that the individual had experienced substantial changes in personality and independence within the previous 12 months. As a result, it was unlikely that older assessments would be sufficiently accurate to provide the information necessary to develop a behavior intervention.
- For Individual #690, no formal behavior assessments were presented in the behavior assessment report dated 8/21/2013. A behavior intervention plan dated 9/25/2013 referenced only a behavior assessment completed on 8/26/2011, but described that assessment as not differentiating the functions of the target behavior clearly. The target behavior in question involved self-injury, which during the month immediately prior to the behavior intervention plan had been displayed 77 times. As a result, it was unlikely that sufficient information

| # | Provision | Assessment of Status | Compliance |
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| | | about the self-injury was known to ensure that an effective intervention could be developed.<br><br>During the current site visit, a sample of 12 records was used to assess the integration of mental illness and behavior assessments. This sample was the same as reported immediately above, minus Individuals #208 and #565 who were not diagnosed with any mental illness. The findings of the review are presented in the table below. | |

| | 3/2010 | 7/2013 | 1/2014 |
|---|---|---|---|
| The assessment process included screening for psychopathology, emotional, and behavioral issues. | 0% | 100% | 92% |
| The assessment process included differentiation between learned and biologically based behaviors. | 0% | 74% | 33% |
| Identification of behavioral indices of psychopathology | 0% | 74% | 33% |
| Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities | 0% | 84% | 83% |

Based upon the review of the current sample, it was evident that the majority of behavior assessments include abundant information about each individual's mental illness and history of psychiatric services. It was not evident, however, that the necessary formal assessment practices were used to identify relationships between mental illness and environmentally based behavior and formulate an integrated approach to addressing behavioral and psychiatric disturbances. Examples of where the Facility fell short in this area are presented below.

- Individual #311 was diagnosed with dementia and Down syndrome, and was prescribed Namenda. Behaviors attributed to his dementia included restlessness, agitation, and yelling at others. Although such behaviors often can be affected by environmental factors and serve specific purposes even in people with dementia, no behavior assessments targeted these behaviors.
- The behavior assessment dated 10/11/2013 for Individual #753 stated that the individual "does not currently receive any psychiatric services so there are no psychiatric symptoms to report on." This same report later stated that the individual was prescribed 1500 mg per day of Depakote to address symptoms of her mental illness. The psychiatric assessment dated 10/11/2013, however, stated that the individual was prescribed 100 mg of Seroquel daily to address symptoms of intermittent explosive disorder, such as physical aggression

| # | Provision | Assessment of Status | Compliance |
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| | | toward others and property. These are the same behaviors targeted by the individual's behavior intervention. Based upon the available information, it appeared that both the behavior and psychiatric interventions targeted the same behaviors without rationale showing how the interventions complemented each other or addressed different aspects of the behaviors. Due to the conflicting statements provided in various assessments and interventions, it was suggested that the assessment and intervention efforts were separate and parallel efforts, rather than an integrated approach to behavior and psychiatric supports.<br><br>Based upon the documentation provided by the Facility, it was apparent that the Facility was often able to conduct thorough and sophisticated assessments of behavior and mental illness. Too frequently, however, the Facility failed to ensure that all assessments were thorough, timely, and accurate. Furthermore, although behavioral staff often provided extensive assessments, in the majority of circumstances, these efforts lacked the necessary rigor. Furthermore, there were instances in which information in the assessments raised questions about how well the case formulations and interventions were integrated.. As a result, it was determined that the Facility had not achieved substantial compliance with the Settlement Agreement. | |
| K6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data. | According to information obtained from the review of the sample presented in K.5, the following conclusions were reached.<br>• Intelligence tests had been completed within the past five years for 38 of 494 individuals (8%).<br>• Testing of adaptive skills had been completed at least annually for 120 of 468 individuals (26%).<br>• Psychological evaluation reports had been completed at least annually for 342 of 494 individuals (69%).<br><br>Based upon the information reviewed, it was evident that many of the psychological assessments at the Facility were neither current nor included complete clinical and behavioral data. | Noncompliance |
| K7 | Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the | Information provided to the Monitoring Team prior to the site visit reflected that six individuals were admitted to the Facility since the previous site visit, Individuals #280, #281, #459, #666, #668, and #800. Facility tracking spreadsheets reflected that only two of these individuals (Individuals #280 and #666, 33%) had been provided intellectual and adaptive assessments, with only Individual #666 having being provided an assessment report. Facility tracking spreadsheets reflected that none of the six recently admitted individuals (0%) had been provided with behavior assessments. | Noncompliance |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>Despite the tracking data presented above, the Facility provided written reports for three of the six recently admitted individuals (Individuals #280, #459, and #666, 50%). Based upon the three submitted reports, the following circumstances were noted.<ul><li>One of six recently admitted individuals (Individual #280, 17%) was provided with intellectual and adaptive skill assessments within 30 days of admission.</li><li>Three of six recently admitted individuals (Individuals #280, #459, and #666, 50%), were provided with behavior assessments within 30 days of admission.</li><li>Three of six recently admitted individuals (Individuals #280, #459, and #666, 50%), were provided with psychological assessment reports within 30 days of admission.</li></ul>Based upon the information presented by the Facility, it was suggested that individuals admitted to the Facility were not routinely provided with the necessary psychological assessments. Furthermore, it was concerning that the Facility was not able to provide tracking records that reflected actual activities.</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>The Facility submitted material on 10 individuals receiving in counseling services. This material included treatment plans, counseling meeting minutes, and the latest treatment progress notes. The specific individuals included in the sample were Individuals #64, #79, #110, #119, #182, #216, #231, #306, #629, and #781. The table below presents information obtained from the review of the 10 records.
<table>
<tr><th></th><th>1/2010</th><th>7/2013</th><th>1/2014</th></tr>
<tr><td>Needed services identified in the psychological assessment are implemented within 6 weeks of the assessment</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Service/treatment plan includes initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target)</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Services are goal directed with measurable objectives and treatment expectations</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Services reflect evidence-based practices</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or</td><td>0%</td><td>100%</td><td>100%</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>number of sessions without meeting the learning goal that will trigger review and revision of intervention</td><td></td><td></td><td></td></tr>
<tr><td>Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Service identified in ISP and, if applicable, PBSP</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists</td><td>0%</td><td>100%</td><td>100%</td></tr>
</table>
<br>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. 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.
</td><td></td></tr>
<tr><td>K9</td><td>By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP.</td><td><u>PBSP Approval and Consent</u><br>The Behavior Services tracking spreadsheet included implementation dates for 49 PBSPs. Of those 49 PBSPs, the tracking spreadsheet did not include a date for Human Rights Committee approval for 14 PBSPs. Therefore, it was not evident that Human Rights Committee approval had been obtained prior to the implementation of 14 of 49 PBSPs.<br><br>A review of Facility tracking data also reflected that the Facility experienced difficulty in implementing PBSPs promptly after approval and consent were obtained. For 14 of 49 PBSPs completed since the previous site visit (29%), there was a delay of greater than 14 days between consent and implementation. The average noted delay was 17.29 days.<br><br>During the current site visit, the Monitoring Team selected a sample of 14 individuals for the review of behavior intervention plans. This sample included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.</td><td>Noncompliance</td></tr>
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| # | Provision | Assessment of Status | Compliance |
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| | Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances. | | |

| PBSP Element | 3/2010 | 7/2013 | 1/2014 |
|---|---|---|---|
| Rationale for selection of the proposed intervention | 50% | 100% | 79% |
| History of prior intervention strategies and outcomes | 50% | 100% | 79% |
| Consideration of medical, psychiatric and healthcare issues | 40% | 100% | 79% |
| Operational definitions of target behaviors | 70% | 100% | 43% |
| Operational definitions of replacement behaviors | 70% | 100% | 50% |
| Description of potential function(s) of behavior | 30% | 100% | 50% |
| Use of positive reinforcement sufficient for strengthening desired behavior | 10% | 100% | 71% |
| Strategies addressing setting event and motivating operation issues | 60% | 100% | 86% |
| Strategies addressing antecedent issues | 60% | 100% | 86% |
| Strategies that include the teaching of desired replacement behaviors | 10% | 50% | 71% |
| Strategies to weaken undesired behavior | 30% | 100% | 79% |
| Description of data collection procedures | 20% | 100% | 64% |
| Baseline or comparison data | 0% | 100% | 71% |
| Treatment expectations and timeframes written in objective, observable, and measureable terms | 0% | 100% | 93% |
| Clear, simple, precise interventions for responding to the behavior when it occurs | 30% | 100% | 93% |
| Plan, or considerations, to reduce intensity of intervention, if applicable | 0% | 100% | 86% |
| Signature of individual responsible for developing the PBSP | 90% | 100% | 100% |

The ratings achieved during the current site visit reflect a considerable regression from previous levels of success. A closer examination of the submitted records, however, suggested a combined effect of two specific factors leading to the decline in ratings that did not necessarily reflect a significant, facility-wide deterioration in performance. The first reason involved the lack of patterns or trends in weaknesses for most behavior intervention plans.

- Three of the 14 records (21%) reflected sophisticated behavior interventions

| # | Provision | Assessment of Status | Compliance |
|---|---|---|---|
| | | with no obvious significant flaws.<br>• An additional six of 14 records (43%) reflected competent intervention plans with isolated omissions of specific components, such as the description of data collection for replacement behaviors.<br><br>Based upon this information, 64% of the reviewed behavior interventions were generally of adequate quality or above.<br><br>The second factor involved behavior intervention plans for four individuals (Individuals #311, #637, #690, and #753) that were based upon particularly weak behavior assessments. Because of the lack of adequate assessment, it was not possible to develop an adequate behavior intervention plan. When the plans for these four individuals were combined with the six plans with isolated omissions, the result was a substantially reduced rating for the majority of areas within Provision K.9.<br><br>Although the above information to some degree mitigated the substantial drop in ratings, the Facility must be cautious in interpreting this information. Isolated problems might be indicative of no more than chance or a subset of staff who were temporarily under-performing. Conversely, however, the onset of a variety of weaknesses, no matter how isolated, could be indicative of systemic weaknesses in the monitoring and peer review process. If the latter hypothesis was correct, then the current low ratings, rather than an aberration, could be indicative of even worse performance in the future. The Monitoring Team encourages the Facility to aggressively assess the status of behavior assessment and intervention practices facility-wide to ensure that any necessary corrective actions are developed and implemented diligently. | |
| K10 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications. | <u>Historical Perspective</u><br>During the April 2012 site visit, the Facility reported that the data collection procedure had not changed since the previous site visit. It was reported, however, that substantial changes had been recently introduced to the data presentation and progress note format. These improvements included changes to the graphing process, increased use of condition-change lines and annotations, and the integration of psychiatric target symptom tracking. The Facility reported that the intent of the changes was to improve the ability to assess the response to treatment.<br><br>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. The July 2013 site visit reflected improvement in many areas relating to data presentation.<br><br><u>Current Site Visit</u> | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
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| | | During the current site visit, the Monitoring Team selected a sample of 14 individuals for the review of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774. | |

| Graph Element | 3/2010 | 7/2013 | 1/2014 |
|---|---|---|---|
| The graph is appropriate to the nature of the data. | 100% | 100% | 64% |
| Horizontal axis and label | 100% | 100% | 100% |
| Vertical axis and label | 0% | 88% | 71% |
| Condition change lines | 0% | 100% | 79% |
| Condition labels | 0% | 100% | 86% |
| Data points and path | 0% | 100% | 93% |
| IOA and data integrity | 0% | 0% | 0% |
| Demarcation of changes in medication, health status or other events | 0% | 100% | 79% |

Based upon the review of the PBSPs and data graphs, it did appear that modest regressions had occurred in many areas. Examples of particular issues that contributed to this regression are presented below.

- Graphs for Individual #4 combined treatment targets and replacement behaviors into a single graph with a single y-axis. Treatment target data could range from zero to 300. Replacement behavior data, however, was limited to a maximum of two. The effect was to flatten replacement behavior data trends and hide any changes in skill acquisition. The data graph should have included a secondary y-axis with a separate scale for replacement behavior.
- Target behavior data for Individual #208 were reported as monthly total frequency. In the data graphs, as well as comments by the program author, it was noted that the targeted behavior occurred in isolated outbursts during a small number of days each month. Other methods of collecting and presenting data, such as the number of days each month involving behavior displays or the interval between days with behavior displays, could have enhanced the treatment monitoring process.
- In most graphs, a vertical line, sometimes called a condition change or phase change line was inserted to show when something had changed for the individual, usually a medication change or a revision to a behavior intervention. In some graphs, the vertical lines were drawn through the trend lines, the lines that run from one data point to another. In several other graphs, the trend line stopped prior to the condition change line and then restarted

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<tr><td></td><td></td><td>after the condition change line. Where there were few condition change lines on a graph, this introduced no substantial issues. Those graphs that included several condition change lines, however, often lacked meaningful trend lines and appeared to consist of multiple isolated data points.<br><br>The Monitoring Team also reviewed reliability data practices for the 14 individuals in the sample. Ratings are presented in the table below.<br><br>
<table>
<tr><td colspan="2">Inter-observer agreement exists for PBSP data</td><td>3/2010</td><td>7/2003</td><td>1/2014</td></tr>
<tr><td></td><td>IOA for target behavior data</td><td>0%</td><td>0%</td><td>71%</td></tr>
<tr><td></td><td>IOA for replacement behavior data</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td></td><td>IOA meets minimum criteria</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>
<br>Records reflected that some IOA data for treatment targets were reported for 10 of the 14 individuals (71%). It was commendable that the Facility was able to provide at least some IOA data. In most cases, however, IOA was reported for non-occurrence rather than occurrence of the target. When behaviors occur only very infrequently (as in the case of behaviors that rarely occur but are severe when they do occur), agreement on non-occurrence is likely to be very high even if there is little agreement when the behavior is recorded as occurring; that is, observers can easily tell when the behavior clearly does not occur but do not similarly recognize when it does occur (indicating they are using different definitions, or that the definition of the behavior is unclear). It is recommended that the Facility develop and implement strategies to enhance reliability measures, so data clearly measure when these behaviors occur.</td><td></td></tr>
<tr><td>K11</td><td>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.</td><td>During the current site visit, the Monitoring Team selected a sample of 14 individuals for the review of the readability of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, or behavior interventions. The specific individuals included in the sample were Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br><br>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 sample of 14 records (Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774) revealed that that the readability requirement was enforced by the peer review process.</td><td>Substantial Compliance</td></tr>
<tr><td>K12</td><td>Commencing within six months of</td><td>The Facility indicated that verbal instruction, competency-based training (CBT),</td><td>Noncompliance</td></tr>
</table>

| # | Provision | Assessment of Status | Compliance |
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| | 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. | modeling, and demonstration strategies were used to train DSP staff on behavior intervention plans. There was no indication of the frequency or setting within which various training modalities were used. The Facility did not provide tracking data reflecting which staff attended the training or the performance of those staff during and following training.<br><br>Due to the limitations in the provided documentation such as tracking data on training, the following weaknesses were evident.<br>• There was no indication that the Facility had implemented a comprehensive system of integrity checks to assess staff competence in reference to PBSPs and to provide competency-based retraining as needed.<br>• The Facility did not present documentation that certain PBSPs had been identified as requiring CBT for all staff working with a particular individual.<br>• The Facility did not present a measure or system for assessing the competence of staff in relation to challenging behaviors that occur infrequently. | |
| 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, the Facility employed 12 staff who possessed board certification as a behavior analyst. This represented approximately 1 BCBA for every 39 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 a BCBA credentialed employee fill each available position, the Facility would achieve approximately a 1:23 ratio. The Facility also employed sufficient Psychology Assistants to provide one Psychology Assistant for every two full-time psychologists. | Noncompliance |

| SECTION L: Medical Care | |
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| | **Document Reviewed:**<br>1. DSSLC Self Assessment, 12/27/2013<br>2. DSSLC Action Plan, 12/5/13<br>3. DSSLC Presentation Book<br>4. DADS Medical Care Policy: 009.2, dated 5/15/2013<br>5. DSSLC Policy: CMGMT 03 Integration of Clinical Services, dated 12/1/2013<br>6. DSSLC Policy Medical 01 – Medical Care, Medical Management Assessment of Assessments, 9/1/2013<br>7. DSSLC Policy Medical 01, Medical Quality Assurance, 07/01/2013<br>8. DSSLC Quality Assurance Death Review Protocol 07/01/2013Medical 07 – Death of an Individual Policy, 12/1/13<br>9. DSSLC Policy Committees and Councils – 07A Clinical Death Review Policies and Procedure Manual 5/15/06<br>10. DSSLC Policy Committees and Councils – 07B Administrative Death Review Committee, Policies and Procedure Manual 5/1/06<br>11. DSSLC Policy Medical 07 – Death of an Individual, Exhibit A – Quality Assurance Death Review Protocol, 12/1/13<br>12. DSSLC Unusual Incident Investigation (URI) Reports of Deaths for Individuals #750, #575, #443, #710, and #769<br>13. DSSLC Death/Discharge Summaries for Individuals: #750, #575, #443, #710, and #769<br>14. Autopsy Associates of North Texas Report for Individuals: #750 and #443<br>15. Texas Department of State Health Services – Vital Statistics Unit, Death Certificates for Individuals #750, #575, #443, #710, and #769<br>16. DSSLC Quality Improvement Death Review of Nursing Services for Individuals #750, #575, #443, #710, and #769<br>17. DSSLC Clinical Death Review Committee Recommendation Reports for Individuals #750, #575, #443, #710, and #769<br>18. DSSLC Administrative Death Review Recommendation Reports for Individuals #750, #575, #443, #710, and #769<br>19. DSSLC Death Review Recommendation Tracking Log for each Death for Individuals #750, #575, #443, #710, and #769<br>20. DSSLC Death Review Compliance Report Tracking Log<br>21. Written statement by the medical director indicating that the results of medical provider quality assurance audits were discussed with each provider<br>22. Copies of completed internal and external medical provider quality assurance audit assessment tools<br>23. Graphs and data sheets related to medical quality assurance (Dates not provided)<br>24. Curriculum vita for all licensed medical providers<br>25. Copy of current medical license for two medical providers<br>26. Copy of current CPR certificate for all medical providers (the Monitoring Team requested all but received two)<br>27. List of all CMEs obtained during the past 12 months for all medical providers<br>28. List of all female individuals 40 years old and older |

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| | 29. List of all individuals who were current and not current with their annual mammogram screen<br>30. Documentation by the Facility indicating the rationale why individuals were not current with their annual mammogram<br>31. List of all men age 50 and older, and for the last ten individuals on the list (Individuals #248, #351, #353, #52, #632, #553, #788, #32, #27, and #791):<br>a. Copy of their PSA test results<br>b. Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing<br>c. Rationale why annual PSA testing was not completed<br>32. List of all individuals diagnosed with osteoporosis, and for the first five individuals on the list (Individuals #11, #705, 474, #279, and #445):<br>a. Most recent annual medical assessment<br>b. Most recent medication list<br>c. Most recent two bone density studies<br>d. Most recent labs for the past 12 months<br>e. Most recent IRRF<br>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<br>33. List of all individuals with diagnosis of malignancy, and history of malignancy<br>34. For Individual #243:<br>a. Active clinical record<br>b. Annual ISP<br>c. OTPT annual summary, dated 7/23/2013<br>d. PMNP meeting minutes for Individual #243, dated 1/9/2014, 11/14/2013, 12/19/2013, 10/18/2013, and 10/24/2013<br>e. Emergency room records and Cervical CT report, dated 1/16/2014<br>f. Annual psychiatric summary, dated 8/19/2013<br>g. Annual Physician's Summary, dated 7/11/2013<br>35. For the last five individuals on the list of individuals diagnosed with malignancy (Individuals #228, #66, #326, #492, and #483):<br>a. Annual medical summary<br>b. Most recent two physician quarterly reviews<br>c. Most recent IRRF<br>d. All IDT related minutes specific for diagnosis of malignancy<br>e. Last six months IPNs by the medical provider that specifically documented assessment of malignancy<br>f. All consultation reports specific for the diagnosis of malignancy<br>36. List of all individuals who experienced a diagnosis of pneumonia during the reporting period<br>37. List of individuals who experienced a diagnosis of pneumonia during the reporting period, and who also experienced recurrent pneumonia, more than three episodes of pneumonia within the past five year (Individuals #499, #66, #336, #305, #551, #423, #351, and #743).<br>38. For the five individuals who experienced the most numerous incidences of recurrent pneumonia, from |

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|---|---|
| | the list of those with recurrent pneumonia (Individuals #336, #305, #551, #499, and #66):<br>a. Most recent annual medical summary<br>b. Most recent IRRF<br>c. Most recent PT-OT assessment<br>d. Current medication list<br>e. Medical consultations that specifically evaluate the individual to help mitigate recurrent pneumonia<br>f. Most recent PNMT minutes<br>39. Alpha list of all individuals with diagnosed seizure disorder<br>40. Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period<br>41. List of all individuals with diagnosis of status epilepticus<br>42. List of all individuals with implantable VNS<br>43. For the first five individuals on the list of individuals with VNS, copy of the most recent VNS interrogation report<br>44. For the last five individuals on the lists of individuals diagnosed with status epilepticus (Individuals #170, #251, #42, #656, and #664):<br>a. Annual medical summary<br>b. Most recent two quarterly physician summaries<br>c. Most recent two neurology consultation reports<br>d. Current medication list<br>e. Most recent EEG<br>f. Most recent brain imaging report<br>g. Current six months medical provider's IPNs, specific for management of seizure disorder<br>h. IDT meeting minutes documenting supports and services necessary for the management of seizure disorder<br>i. Seizure log<br>45. For Individual 567<br>a. Hospital discharge summary from 10/3/2013, and 12/17/2013 hospitalizations<br>b. CT of abdomen and pelvis report from 10/14/2013 hospitalization<br>c. EGD, colonoscopy and biopsy reports 10/3/2013<br>d. Active clinical record<br>46. VNS interrogation report for Individuals #781 and #674<br>47. List of all individuals with do not resuscitate orders (DNR), and for the last five individuals on the list:<br>a. Most recent ISP<br>b. Most recent annual medical assessment<br>c. DNR ethics review minutes<br>d. Most recent DNR order form<br>48. List, by condition, of any standardized clinical indicators routinely used to assess progress or status of individuals with chronic healthcare conditions<br>**People Interviewed:**<br>1. Delia Schilder, RN, Chief Nurse Executive (CNE) |

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| | 2. Sherri Courtney, RN, Nursing Operations Officer (NOO)<br>3. Laura Stoffels, RN, Nurse Investigator<br>4. Diane Porter, RN, RN Case Manager Supervisor<br>5. Stephen Kubala, MD, Medical Director<br>6. Diane Tompkins, Health Services Compliance Officer<br>7. Clair Thompson, State Office Observer<br>8. Randy Spence, MS, BCBA<br>9. Diane Porter, RN CN Supervisor<br>10. Dinesh Kagal, MD<br>11. Stacy Draus, RN PNMT<br>12. Erin O;Toole MS CCC-SLP, PNMT<br>**Meetings Attended/Observation:**<br>1. Mortality Review Committee Meeting<br>2. Observational assessment at living area<br>a. Cedar Falls, 1/16/2013<br>b. Timberhill, 1/15/2014<br>c. Infirmary, 1/16/2016, and 1/17/2014<br>3. Annual ISP meeting for Individual #228<br>4. Integrated Morning Report, 1/15/2014 |
| | **Facility Self-Assessment:**<br>The Monitoring Team concurred with the Facility's Self-Assessment of noncompliance of Sections L.1, and L4; however, the Monitoring Team does not agree with the Facility's Self-Assessment of substantial compliance for Sections L.2, and L.3.<br><br>The Facility's Self-Assessment for Sections L1, through L3 utilized necessary and appropriate questions that were data-driven, and probed necessary areas for each section, to help determine substantial compliance, and noncompliance. For example, the Self-Assessment specifically addressed timeliness of completing medical assessments, and if the medical assessments and treatments were adequate. The Facility, however, utilized data derived from the Facility's medical quality assurance process and the medical provider's quality assurance audit process, which the Monitoring Team's determined not to adequately assess standard of care practice. For example, the Self-Assessment determined that the Facility was in 100% compliance by adequately addressing the individual's health care needs; the Monitoring Team, however, determined that the Facility was not in substantial compliance because, in its examples for the management of seizure disorder and pneumonia, and in two comprehensive case reviews, among others, the Facility did not adequately address the individual's clinical needs. The Self-Assessment also stated that the Facility was experiencing a slight downward trend in pneumonia, and specifically aspiration pneumonia continued to decrease; the Monitoring Team determined that total cases of pneumonia were increasing, and that the Facility was not appropriately documenting aspiration events. The Self-Assessment of the Facility's mortality review process documented that the mortality reviews were timely, that action plans were being tracked to completion, and that recommendations and corrective actions had been identified. While the Monitoring Team determined that the mortality reviews were timely, and that |

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| | some action plans were identified and tracked to completion, the Facility did not perform effective mortality reviews that would lead to identification of issues that may have contributed to the death, and did not develop all necessary corrective actions to address staffing and systems related issues. The Monitoring Team does concur with the Self-Assessment indicating that "existing policies and guidelines do cover the basic provisions however additional policies, procedures and guidelines have been identified as needing to be developed". Specific to Section L.4, the Facility did not utilize data to determine the extent that Facility was actually following its policies and procedures. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team has serious concerns over medical services at the Facility. Follow-up through to full resolution of medical issues; exploring underlying etiology of medical conditions; assertive and meaningful participation by medical providers within the context of the interdisciplinary team process; conducting efficacious assessment of performance standards of medical providers; ensuring a process that effectively determines the quality of medical services by collecting sound clinical data, analyzing the data, and developing and following up on effective action plans; developing, implementing and updating medical policies and procedures that delineate all areas of clinical, and clinical-administration activities; and ensuring a robust mortality review process, were some of the areas observed by the Monitoring Team to need improvement. The following is a more detailed summary of some of the Monitoring Team's concerns, and observations:<br><br>**Section L.1:** The Monitoring Team noted significant areas of concern specific to medical providers' participation in interdisciplinary team meetings and the morning medical meeting. The Facility was not ensuring that underlying causes of low bone mineral density was assessed, was not assessing efficacy of supports and services for the management of recurrent pneumonia, and was not routinely clinically assessing Individuals following seizure activity. The Facility did not have an effective method of identifying and tracking aspiration related pulmonary events, such as aspiration pneumonia and pneumonitis. Clinically relevant follow-up with prostate specific antigen monitoring was not obtained as clinically indicated, despite potential prostate pathology. In general, the Facility was not actively attempting to identify underlying causes of clinical issues, but was merely treating overt manifestations. It is essential that all clinical conditions be evaluated for the underlying etiology of the condition, and that the IDT is well informed on all medical conditions, the etiology of medical conditions, how the condition impacts the life of the individuals, and all potential treatments, and associated risks and benefits of treatment and of not providing treatment for a medical conditions. However, the Monitoring Team noted continued and significant improvement with the diagnosis, monitoring and treatment of low bone density. The Facility must also review, and enhance it's process of determining qualifying conditions for DNR orders, ensure that there is a meaningful ethics and IDT review for the DNR order, and that the DNR order form is appropriately completed.<br><br>**Section L.2**: Regarding the DADS procedure for the internal and external medical provider audits, the Monitoring Team continues to have concerns that the external medical provider quality assurance audit process does not assess the medical providers clinical performance, and strongly recommends that the Facility review the audit tools, specific for this function. The audit tool should assess if the medical |

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| | provider is performing at the level of standard of care practice for medical conditions commonly identified in individual with complex physical and intellectual disabilities, and the assessment should ensure that it only assesses the medical provider that it is intended to assess. The Monitoring Team recognizes that the Facility has developed a new process call the medical assessment of the assessment, which employs an external physician as the reviewer; however, this process has not been fully implemented, and there was no process to ensure tracking of action plans for deficient items. The Monitoring Team will comprehensively review this new process once it is fully implemented, and there is a mechanism to track and follow-up on all actions plans, systemic, and those developed for the medical provider.<br><br>**Section L.3**: The Facility had recently developed a new process to assess medical quality assurance at the Facility, called the assessment of the assessment. This process had yet to be fully implemented, and required formalization. The Monitoring Team will conduct a comprehensive review of this process at subsequent Settlement Agreement reviews. The Facility's medical director outlined this new process, and the Monitoring Team believes that this new process may enhance the Facility's medical quality assurance process. The internal medical provider quality assurance audit process did not provide an effective means to assess clinical outcomes; refers to Section L.2 of this report for additional concerns and comments regarding the medical provider quality assurance audit process. Section L.3 requires that the Facility to develop a medical quality improvement process that collects data relating to the quality of medical services and healthcare status for many common and/or very serious conditions, looks at systems trends and outcomes of medical care, and identifies issues needing to be addressed. For example, the process should be looking at trends analysis of pneumonia, and addressing means to help mitigate the incidences of pneumonia; systems issues may require the Facility to address performance issues of the medical provider, or providers. Although the Facility provided lists of clinical indicators, review of other documentation did not verify that all indicators were reviewed regularly. The Monitoring Team has serious concerns with the lack of a comprehensive review of historical level of care that resulted in the death, contributed to the cause of death, or possibly contributed to the cause of death of individuals. The Monitoring Team provided members of the Mortality Review Committee with specific examples, and concerns by the Monitoring Team.<br><br>**Section L.4:** The Facility had yet to develop and implement all necessary policies and procedures necessary for clinical operations. It is essential that a medical facility have updated policies and procedures that clearly delineate all aspects of clinical, and clinical-administrative activities, and implement such policies. |

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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 | 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:<br>• Medical Administration | Noncompliance |

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| | 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. | • Medical provider's participation in the IDT process<br>• Seizure Disorder<br>• Preventive health issues: prostate cancer screening, and breast cancer screening<br>• Recurrent pneumonia<br>• DNR<br>• Osteoporosis<br>• Malignancy<br><br><u>Medical Administration</u><br>The Monitoring Team assessed licensure status of the Facility's medical staff, CPR certification, clinical documentation practice, and the Facility's regularly scheduled interdisciplinary meetings. To help with the assessment the Monitoring Team reviewed the following documentation:<br>• List of all medical providers, including number of hours worked, case load, and employment status<br>• For each medical provider<br>o Curriculum vita for all licensed medical providers<br>o Copy of current medical license for two medical providers<br>o Copy of current CPR certificate for all medical providers (the Monitoring Team requested all but received two)<br>o List of all CME obtained during the past 12 months for all medical providers<br>• Copy of morning medical meeting minutes for the first meeting of each month during the reporting period.<br><br>Medical Providers:<br>The Facility maintained one full time clinical director, six full time staff physician, one part time contract physician, and two nurse practitioners. Copies of current medical licenses were provided and all medical providers were currently licensed in the State of Texas.<br><br>Copies of a current CPR certificate were provided for nine out of the ten medical providers (90%); one provider was issued a reasonable accommodation certificate, and was not expected to participate in CPR.<br><br>There was a current copy of practice agreements for each of the two nurse practitioners. The Monitoring Team verified with the Texas Medical Board, per its website, to ensure that the physician delegated to each of the nurse practitioners, was registered with the Texas Medical Board. | |

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| | | Medical Meetings:<br>The Facility conducts a daily morning meeting, that meets on regularly scheduled business days, to conduct a review of all on-call issues that occurred the previous night, review current hospitalizations, update on individuals in the infirmary, and to discuss significant clinical. The meeting includes staff members from the living area, occupational and physical therapy, respiratory therapy, psychology, pharmacy department, as well as nursing and physician services.<br><br>The Monitoring Team attended the morning meeting on 1/20/2013, and noted the following:<br>The meeting included members from the pharmacy department, nursing, and medical services, psychology department, PTOT, and respiratory therapy. Despite the multidisciplinary attendance, the meeting was not conducted in a multidisciplinary format there was limited participation by attendees. The meeting was mostly a reciting form a list of issues that occurred from the following day, with little or in most cases no clinical discussion. The Monitoring Team could not discern the efficacy of the meeting.<br><br>The Monitoring Team reviewed the morning meeting minutes from 8/1/2013, 9/3/2013, 10/1/2013, 11/1/2013, and 12/2/2013. The Monitoring Team could not gain clinical insight into the issues addressed, and outlined in the minutes. For example:<br>• Minutes on 11/1/2013 indicated that Individual #404 was "lethargic sent to DRMC"; however, there was no additional information documented, and no action plan developed to follow-up on the issue of lethargy.<br>• On 12/2/2013, the minutes documented that individual #118 was diagnosed with "PNA" and "home today"; the minutes also indicated that the issue was "closed", implying no follow-up was necessary. There was no further comment, discussion, or action plan developed.<br>• On 8/1/2013 the minutes documented that Individual #251 was "transfer from Lufkin. 4 minute seizure, refuse seizure meds", and there was no comment or action plan developed<br>• The minutes from 9/3/2013 indicated that Individual #605 "abd pain went to DRMC – nothing wrong"; however there was no further explanation as why the Individual manifested abdominal pain, what was done at the hospital, and what additional follow-up may be requires. Nothing else was documented.<br>• The minutes on 10/1/2013 documented that Individual #605 "C/O abd pain to DRMC ER" and "Dr. (medical provider) called family – sent to ER during regular hours Back from ER labs normal. There was no additional documentation about this issue. For example, no one at the meeting commented that this Individual was sent to the ER for similar chief complaints on 9/3/2013, as reported in the 9/3/2013 minutes. There was no comment, discussion, or recommended | |

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| | | follow-up to determine the reason for the chief complaint of abdominal pain.<br><br>By the Monitoring Team's direct observation of the morning meeting, and review of the morning meeting minutes, the Monitoring Team is concerned over the efficacy of this process. A daily clinical meeting should discuss all relevant issues in a multidisciplinary approach. Medical providers participation at the meeting must be significantly enhanced, and the medical provider must provide clinical rationale regarding each clinical issue discussed.<br><br>Medical Provider's Participation in the Interdisciplinary Team Process (IDT):<br>The Monitoring Team observed the annual ISP for Individual #228, and made the following observations:<br><br>Individual #228 was known to have significant medical issues, including a history of thyroid cancer, breast cancer, severe dysphagia with episodes of recurrent aspiration pneumonia, syringomyelia of the thoracic spine, prostatic hyperplasia with urinary retention and recurrent urinary tract infections, recurrent aspiration pneumonia, obstructive sleep apnea, degenerative joint disease of the spine, with signs of compression and prolapse discs, and colon polyps, among other diagnosis. In addition, there were conditions identified by other medical consultants, and diagnostic tests, although not listed on the annual medical assessment, or active problem list, including cataracts, hypoprotienemia, and anemia. Additionally, the Individual was noted by the Monitoring Team to have a raised, black, hyperpigmented lesion on the right maxillary region of the face, and the physical assessment did not comment on this lesion.<br><br>The following are some of the concerns noted by the Monitoring Team during its observation of the ISP meeting:<br>• The Individual was known to have had two cancers, including cancer of the thyroid, and male breast cancer. Additionally, a first-degree relative was noted to have died from cancer. The associated risks of cancer was not discussed during the ISP meeting.<br>• The issue of worsening dysphagia was raised at the ISP meeting, and there was some discussion about aspiration risks, however, there was no discussion about the etiology of the worsening dysphagia. It is essential that the Facility explore all possible causes of dysphagia.<br>• A non-Facility participant raised concern over the Individual's significant obesity, and there was no evidence that the Facility had clinically evaluated the Individual's weight gain. Furthermore the Facility did not take into consideration that the Individual had an abnormal thyroid result. Despite a normal TSH, the low T3 and elevated T4 may indicate that the thyroid gland is | |

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| | | not able to convert T4, to T3. This issue should have been further explored at the ISP meeting.<br>• Blood counts indicate a diagnosis of anemia; however, a diagnosis of anemia was not noted on the annual medical assessment or acute problem list, and was not discussed at the ISP meeting.<br>• The Individual had two colonoscopies. The first colonoscopy reported adenomatous polyp, and a follow-up colonoscopy in 2012 reported that a polypectomy was completed, however, the annual medical assessment, and the IRRF document indicated that the pathology report was not reviewed, and the Facility was not aware of the results. The medical provider indicated on the annual medical assessment that a follow-up colonoscopy would be completed in ten years. It is essential that the Facility is made aware of the pathology results, to ensure more timely follow-up. Certain types of polyps require more frequent screening colonoscopies. Also noted on the colonoscopy report was the finding of diverticulosis, and diverticulosis was not indicated as a diagnosis on the annual medical assessment or active problem list. Diverticulosis, and the issue of not knowing the pathology report following the 2012 colonoscopy was not addressed at the IDT.<br>• An ophthalmology report indicated early diagnosis of cataracts, however, this issue was not addressed at the ISP meeting.<br>• The Individual is known to have sleep apnea. Sleep apnea can contribute to obesity, psychiatric issues, and cardiac problems, among other conditions. The Individual was reported not to be compliant with C-PAP treatments, and the issue of non-compliance was not discussed at the ISP meeting.<br>• The Individual is diagnosed with benign prostate hyperplasia, and urinary incontinence, recurrent urinary tract infections, and a cystoscopy indicated pathological changes of the bladder that is consistent with chronic urinary retention. These issues were not addressed at the ISP.<br>• There was evidence in the active clinical record that the Individual has significant pathology of the vertebrae and spine, including syringomyelia, degenerative changes of the spine, which was noted to be compressing the spinal, and root nerves. Such conditions, if not closely monitoring, and assertively managed, may lead to worsening functional decline, including paralysis, and pain. There is also a possibility of cervical spine disease leading to dysphagia. It is essential that the ISP assertively address this issue.<br>• By observation, the Monitoring Team noted that the Individual had a prominent, hyperpigmented lesion over the maxillary region. This lesion was not identified on the physical assessment component of the annual medical assessment, and was not addressed at the ISP meeting. If this was a new lesion, it would warrant assessment by a medical specialist. | |

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| | | The Monitoring Team determined that the Facility did not conduct an effective ISP meeting to address the Individual's health care issues. It should be noted that the Monitoring Team meet with Facility leadership to address the above identified issues, and the Facility was to ensure that the interdisciplinary team would reassess all issues.<br><br><u>Cancer screening</u><br>The Monitoring Team assessed the Facility's ability to provide screening procedures for cancer by reviewing the Facility's screening process for mammography, and PSA screening.<br><br>Mammography:<br>To assess the Facility's breast cancer screening process, the Monitoring Team reviewed:<br>• List of all female individuals 40 years old, and older<br>• List of all individuals who were current and not current with their annual mammogram screen<br>• Documentation by the Facility indicating the rational why individuals were not current with their annual mammogram screen<br><br>The Facility provided a list, "females 40 and over", indicating that 185 females individuals were age 40 years and older, and a second list of individuals who were "females over 40 with most recent mammogram", that included a list of 195 individuals. A third list was provided, Females 40 and over who have not had a mammogram that indicated two individuals had not had a routine screening mammogram with in the prior 12 months. The two lists provided demonstrated a discrepancy of ten individuals, suggesting that the Facility methodology of tracking individuals is not effective, and because of this discrepancy, the Monitoring Team will not comment on the effectiveness of the Facilities management of breast cancer screening. It should be noted, however, that for the two individuals who were reported not to have had an annual screening mammogram, there was sound clinical rationale for not obtaining the<br><br>Prostate cancer screening by PSA blood test:<br>The Monitoring Team reviewed the following documents to assess the Facility's prostate cancer screening program, by means of PSA blood testing:<br>• List of all men age 50 and older<br>• For the last ten individuals on the list:<br>o Copy of their PSA test results<br>o Documentation that the legally authorized representative (LAR) was informed of the risks, benefits, and alternatives to PSA testing<br>o Rationale why annual PSA testing was not completed | |

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| | | The Monitoring Team was provided a list indicating that 148 male individuals age 50 and older resided at the Facility. The Facility provided a list indicating that 14 Individuals had not been provided an annual PSA screening, when clinically indicated; indicating that 91 percent of individuals who were age 50 and older were provided an annual PSA screening.<br><br>For the last ten individuals on the list of all male individuals age 50 and older, the Monitoring Team requested copies of the most recent PSA result, and copy of the IDT minutes that discussed the risks and benefits of PSA screening (#248, #351, #353, #52, #632, #553, #788, #32, #27, #791):<br>• Of the ten examples reviewed, seven out of ten (70%) indicated that annual PSA testing was completed. There was no clinical rationale provided documenting why PSA testing was not obtained for the three examples (individuals #791, #632, and 353) other then "PSA was not ordered"<br>• There was no evidence provided demonstrating the Facility's discussion with the legal representative about the potential risks, benefits, and alternative to PSA testing. Acceptable standard of care practice dictates that the LAR be informed of the risks, benefits, and alternatives to PSA testing.<br><br>The Facility provided documentation regarding why the PSA was not obtained for the 14 individuals, by the Facility as not being current with their annual PSA, along with copies of annual medical assessment (individuals #353, #632, #791, #313, #725, #218, #618, #565, #689, #648, #77, #209, #530, #452):<br>• One of the 14 examples did not require a PSA, as the Individual had only recently turned 50 years old (Individual #313)<br>• Three out of 13 examples (23%) were reported to have symptoms of an abnormal prostate. Individual #218 was reported to have urinary incontinence, Individual #209 had an enlarged prostate examination, and Individual #565 had a history of abnormal PSA; and per recommendation by a urologist was suppose to have had a repeat PSA before the end of 2013.<br>• In zero out of 14 examples (0%), the IDT documented discussion the risks and benefits of annual screening PSAs.<br><br>The Facility reported that 91% of Individuals who required a PSA had a PSA within the previous 12 months; however, the Monitoring Team sample of ten individuals indicated that only 70% of the individuals who required PSA screening, were provided PSA screening. This discrepancy maybe secondary to the difference is sample size, or an incorrect identification by the Facility. The Facility did not ensure that the risks and benefits of PSA screening were clearly discussed by the IDT, inclusive of the legal | |

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| | | representative; current generally acceptable standards of care dictate that the risks and benefit of annual PSA be discussed with the patient, prior to screening. The Monitoring Team is concerned that for the three individuals who were known to have possible abnormal prostates, timely PSA evaluations were not completed.<br><br><u>Osteoporosis</u><br>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 five individuals on the list, a copy of:<br>• Most recent annual medical assessment<br>• Most recent medication list<br>• Most recent two bone density studies<br>• Most recent labs for the past 12 months<br>• Most recent IRRF<br>• 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<br><br>Review of the Facility's "Osteoporosis Guidelines for the PCP" (undated) indicated an excellent general review of osteoporosis; that included information specific to secondary causes of bone density and specific information to help direct care staff better understand the diagnosis of osteoporosis.<br><br>The Facility developed guidelines for Direct Support Professionals (DSPs), Osteoporosis Guidelines For the DSP (undated).<br><br>Review of the requested documents for Individuals #11, #705, 474, #279, #445:<br>• Five out of five samples (100%), indicated the diagnosis of either osteoporosis or osteopenia on the annual medical summary.<br>• Four out of five annual medical summaries (80%) 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.<br>• Five of five samples (100%) indicated that individuals were provided vitamin D, Calcium and a bisphosphonate, or other treatment, when clinically indicated. The Monitoring Team noted that nasal Calcitonin was used at the Facility for long-term treatment of low bone density, and recommends that the Facility assess efficacy of long-term use, and ensure that individuals are able to be appropriately administered nasal calcitonin.<br>• One out of five samples (20%) demonstrated documented evidence that the medical provider fully assessed the individual for potential secondary causes of low bone | |

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| | | density. It is obligatory to ensure secondary causes of osteoporosis are evaluated, especially prior to treatment of males and younger adults.<br>• Three out of five samples (60%) included an assessment of risks associated with osteoporosis on the IRRF. Although the IRRFs for individual's #705, and #445 commented on osteoporosis risk under the heading osteoporosis, there was no comment about osteoporosis being a risk factor for fractures, under the fracture heading.<br><br>The Monitoring Team noted continued and 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, and risks appropriately stratified.<br><br><u>Clinical management of malignancy</u><br>To assess the Facility's ability to provide necessary clinical supports and services for individuals with diagnosed malignancy, the Monitoring Team reviewed the following documents:<br>• List of all individuals with diagnosis of malignancy, and history of malignancy<br>• For the last five individuals on the list of individuals diagnosed with malignancy (Individuals #228, #62, #326, #492, and #483):<br>o Annual medical summary<br>o Most recent two physician quarterly reviews<br>o Most recent IRRF<br>o All IDT related minutes specific for diagnosis of malignancy<br>o Last six months IPNs by the medical provider that specifically documented assessment of malignancy<br>o All consultation reports specific for the diagnosis of malignancy<br><br>It should be noted that the list provided to the Monitoring Team of Individuals diagnosed with malignancy was inaccurate. For example, Individual #483, and #62 did not have a malignancy; albeit #62 did have a pre-malignant diagnosis, and Individual #492 had breast cancer, and not skin cancer. Because Individual #483 did not have a malignancy, the Monitoring Team did not include this example in it's assessment of the management of malignancy.<br><br>The Following is a summary of the Monitoring Team's review of the documents provided:<br>• Two out of four examples (50%) indicated appropriate clinical assessment, and | |

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| | | follow-up by the medical provider, for the diagnosis of malignancy.<br>• Four out of four examples (100%) indicated that clinically appropriate consultations were provided for the diagnosis of malignancy.<br>• Zero out of four examples (0%) included the diagnosis of malignancy on the IRRF, and indicated clinically appropriate necessary supports and services.<br>• Zero out of four examples (0%) indicated specific reference to malignancy, including how the condition impacted the Individual, and all necessary supports and services on the most recent annual ISP.<br>• Five out of four examples (100%) included the diagnosis of malignancy on the active problem list.<br>• One out of four examples (25%) included a clinically rationale action plan on the most recent annual medical assessment.<br><br>The following is a summary of some of the Monitoring Team's concern, and observations for Individual's #66, #326, #492, and #483:<br><br>Individual #66: The Individual was as diagnosed with mild cervical dysplasia on in 2010, and a follow-up gynecologist consultation, on 12/7/2012, indicated that additional follow-up was required within one year. The medical plan on the current medical assessment did not include documentation of the recent history of cervical metaplasia, or need to follow-up with gynecology. There were no documents provided to support the medical provider's routine follow-up of this medical condition. The 10/7/2013 IRRF commented on a history of abnormal Pap smear, but did not indicate the need for continued follow-up with gynecology, and there were no specific monitoring parameters for staff to enhance observation for abnormal discharge and bleeding. There was no evidence indicating that a follow-up gynecology consultation was required within 12 months from the 12/7/2013 gynecology evaluation.<br><br>Individual #326: The active problem list noted on the 10/23/2013 annual medical assessment indicated status post colon resection secondary to invasive adenocarcinoma, that occurred October 2003. The past medical history, significant surgery list, and list of resolved major health problems on the 10/23/2013 annual medical assessment did not comment on the history or treatment of invasive colon cancer. A statement under the heading Interval History stated "11/14/2012 post colonoscopy visit", and an 11/13/2012 colonoscopy report was provided for review. However, the preventive care list on the 10/23/2013 annual medical assessment did not list a 11/14/12 colonoscopy, or the results; the last colonoscopy results reported on the annual medical assessment were from 11/19/2008, stating "diminutive colon polyp, internal hemorrhoids". The results of the colon polyp biopsy from 2008 were not reported, and there was no comment on the active problem list, or medical action plan, addressing internal | |

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| | | hemorrhoids. The medical plan that was documented on the 10/23/2013 annual medical assessment only indicated "monitor signs/symptoms, and repeat colonoscopy 2012 -2014". The medical plan should provide specific monitoring parameters, and a more specific date range for follow-up colonoscopy. The 11/6/2013 IRRF did not comment on the 11/14/2012 colonoscopy findings, or history of GI bleed, and did not provide specific monitoring parameters specific for the monitoring of possible recurrent colon cancer. The 11/6/2013 IRRF also documented that there were no episodes of GI bleeding within the past 12 months; however, the 11/13/2012 colonoscopy report indicated that the Individual was referred because of GI bleeding.<br><br>Individual #492: The Individual was diagnosed with invasive breast cancer in 1995, and a suspicious mass was noted on the breast 6/27/2012. The suspicious breast lesion was followed up on, and was determined to be benign. The most recent active problem indicated a history of invasive breast cancer, and the most recent medical action plan documented a clinically rational plan. There was no documentation about breast cancer, or monitoring parameters for breast cancer, noted on the most recent IRRF, and there was no specific documentation on the most recent annual ISP listing necessary supports and services for the history of breast cancer, such as how this impacts the individuals life, monitoring parameters for staff, and necessary clinical follow-up.<br><br>Individual #483: The Individual was reported on the list of individuals who had a diagnosis of malignancy, however, this Individual did not have an actual malignancy, but had a non-cancerous condition known as neuroleptic malignant syndrome; hence, this example was not reviewed or included as part of the Monitoring Team's assessment of malignancy.<br><br><u>Case Reviews</u><br>The Monitoring Team reviewed the active clinical records for Individual #243, and observed the Individual #243 at the living area. The Individual was reported, by the OT/PT department, on the 7/23/2013 OTPT assessment of current status, to have developed increased tone throughout the upper extremities, "whereas last year had normal tone", which was limiting normal range of motion of the upper extremity. The report also stated that the Individual "was able to grasp objects when placed in the hand; however, this year when something was placed in the hand, (the Individual) was unable to grasp/hold it". The Annual Physician's Summary, dated 7/11/2013, indicated a neurological assessment as "coordination grossly normal. Reflexes equal and bilaterally at 1+ at the Achilles and triceps, 2+ at the patella and biceps. No loss of sensation. CNII-XII grossly intact without localizing signs."<br><br>At the time of the Monitoring Team's observation of the Individual, the Medical Director assessed peripheral reflexes and it was noted that the Individual had significantly | |

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| | | exaggerated biceps, and radial reflexes, that when tapped caused significant and sustained clonus of the lower extremities, bilaterally. Because of these significant changes, the Individual was triaged for evaluation at the local emergency department on 1/16/2014. While at the emergency department, the Individual underwent a CT of the spine without contrast material, dated 1/16/2014, that indicated multilevel mild to moderate bilateral neuroforaminal narrowing in the cervical spine and no evidence of bony high-grade canal stenosis; no evidence of cervical spine fracture; degenerative facet and spondylosis changes throughout the cervical spine; degenerative anterolisthesis of C3 on C4, and C5 on C6; and mild reversal of the cervical lordosis. CT scans, and CT scans without contrast material are not diagnostic for potential soft tissue causes of impingement of the spinal cord, hence, addition diagnostics, such as MRI are consider if clinical manifestations suggest spinal cord involvement, especially if there are corresponding degenerative changes noted by CT scan. The Emergency Room physician recommended that the Individual follow-up with a neurosurgeon, for which contact information was provided to arrange follow-up.<br><br>Review of the PNMT minutes, dated 1/9/2014, 11/14/2013, 12/19/2013, 10/18/2013, and 10/24/2013 documented issues related to the Individual's recurrent pneumonia, but in no instance, did the PNMT address the significant neurological changes noted on the 7/23/2013 OPTP assessment.<br><br>Review of the most recent Annual Physician's Assessment, dated 7/11/2013 did not document concern, or further evaluation for the findings on the PNMT minutes, dated 1/9/2014, and the only action plan documented for the Individual's known degenerative joint disease of the cervical vertebrae, was to "continue with positioning per PNMP and scoliosis clinic PRN". There was no evidence in the active clinical record, in the OTPT, or the Annual Physician's Assessment, that the Individual was referred to specialists or the scoliosis clinic to periodically assess the Individual degenerative spine disease. Furthermore, the active problem list, and the Annual Physician's Assessment, did not document finding from the dorsal spine x-rays from February 2002, that documented degenerative disc disease of the lumbar spine.<br><br>Despite positive findings of degenerative spine disease following x-ray studies, there was no evidence of an assertive action plan to regularly assess the individual for pain, discomfort, or development of myelopathy, and the ISP did not assertively address the issue of degenerative spine disease by determining how the disorder may impact the Individual and the necessary supports and services that are required to adequately support the Individual. The Monitoring Team noted that the last documented imaging study of the vertebrae was obtained in 2000, and that prior imaging documented degeneration:<br>• 1983 Cervical vertebrae reported to be normal | |

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| | | • 1994 cervical x-rays demonstrated degenerative changes in C1-2, and C5-6<br>• 1999 cervical x-rays demonstrated degenerative disc disease of C5, 6, and 7<br>• 2000 dorsal spine x-rays demonstrated thoracic and lumbar scoliosis; and degenerative disc disease of L2 and 3<br>Such findings suggest acquired degenerative changes of the spine that should be regularly assessed for progression and for other clinical manifestation, such as pain, discomfort, loss of function, and functional decline.<br><br>During a meeting with the Individual's primary care provider, the Monitoring Team was informed that the Facility had believed that the Individual's decline was secondary to the diagnosis of dementia, which was diagnosed by the Psychiatrist. The Annual Psychiatric Summary, dated 8/19/2013 indicated that "(The Individual) was seen for a follow-up on 3/27/2013 and was noted stable (and) has been off psych medication since 2/25/2013", and there was no comment on the Individual's physical decline. Furthermore, the Annual Psychiatric Summary dated 8/19/2013 documented "(The Individual's) diagnosis being changed to MDD in full remission, and the Primary diagnosis with Dementia, Alzheimer's types, early onset with behavioral disturbances". Despite the diagnosis of Alzheimer's dementia, the psychiatric assessment did not document a neurological examination, or psychomotor activity; and did not include review of clinical diagnostics, such as imaging studies, specific laboratory evaluation, or psychometric testing to aid in the diagnosis of Alzheimer's dementia. The only imaging study reported was a CT of the head from 2003, and there was no indication if the CT was obtained with contrast material, or the reason for the CT.<br><br>The American Psychiatric Association's Practice Guideline for the Treatment of Psychiatric Disorders, 2006, indicates that when caring for patients with dementia, the "psychiatrist who has overall responsibility for the care of the patient oversees the evaluation, which should at a minimum include a clear history of the onset and progression of symptoms; a complete physical and neurological examination; a psychiatric examination; including a cognitive evaluation; a review the medication; and laboratory studies, i.e., complete blood count, blood chemistry, vitamin B12, toxicology screen, syphilis serology, thyroid function, sed rate", and when "focal lesions (are suspected), a structural imaging study, with CT or MRI should be obtained when caring for patients with dementia". There was no evidence that the psychiatrist had clinically assessed all necessary diagnostics, performed or assessed serial cognitive rating assessments, or assessed the Individual's focal neurological signs and symptoms by performing a neurological examination and obtaining necessary diagnostics.<br><br>Review of the most recent annual ISP, dated 8/19/2013, did not include the most recent annual psychiatric summary, and indicated that the (Individual) no longer required a | |

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| | | psychiatric treatment plan because "based on observations, interviews, and all data reviewed it was believed the medications were no longer providing any benefit to (the Individual) and only exposing (the Individual) to potential side-effects)." The annual ISP did not document concern over specific functional decline, did not address necessary supports and services for the presumed Alzheimer's dementia diagnosis; did not indicate the clinical classification for the dementia diagnosis; did not address the changes noted on the OTPT assessment, and only indicated that OPTP recommended "continue use of diabetic socks". The Monitoring Team is concerned with the IDTs lack of understanding of the severity of the Individual's functional decline, and its role in ensuring that all necessary supports and services were in place for this Individual. In addition, the Monitoring Team is very concerned that the IDT determined that the Individual did not need a psychiatric treatment plan, when in fact, the psychiatrist would be the most appropriate physician to oversee the management of an Individual with dementia, if in fact the Individual has dementia.<br><br>Summary:<br>Degenerative changes of the spine are known to commonly occur in the general population, and are common findings in individuals with developmental disabilities. Furthermore, such conditions are known to be progressive, and with time can manifest severe pain, discomfort, loss of motor activity, exaggerative reflexes, loss of sensation, incontinence of bowel and bladder, and even paralysis, and in extreme cases death. There was no evidence to indicate that the Facility had regularly assessed the individual with specific diagnostics, regular physical assessments targeting functional decline, comprehensive assessment of all reflexes, including primitive reflexes, and documenting range of motion measurements. Specific to the diagnosis of dementia, the psychiatrist should have regularly documented a comprehensive psychiatric assessment that included assessment of focal neurologic signs and functional decline, specific to motor and sensory deficits. In addition, the psychiatrist should have well documented results of all necessary diagnostics, including imaging, laboratory, and psychometric assessments of cognitive decline, and clearly excluded other causes, such as potential myelopathy, as a cause of the Individual's functional decline. The Monitoring Team is also very concerned with the lack of clear understanding of the Individual's functional decline by the IDT.<br><br>Following a review of the most recent ISP for Individual #567, the Monitoring Team noted that the Individual's recurrent episodes of clinically significantly decrease in hemoglobin, and red blood cell count, was not assertively addressed by the Facility.<br><br>Review of the active clinical record indicated that the Individual developed chronic anemia, and experienced two episodes of clinically serious episodes of acute blood loss that required hospitalization and blood transfusions on 10/3/2013, and12/17/2013. The Individual underwent several diagnostic evaluations, while hospitalized, including a | |

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| | | colonoscopy, EGD, and CT of the abdomen and pelvis.<br><br>Due to evidence of lack of clinical documentation, the Monitoring Team was concerned that the following issues were not assertively managed:<br>• Colonoscopy reports indicated that the Individual had internal hemorrhoids, and the Facility did not document consideration of hemorrhoids as a possible source of blood loss, or develop a clinically appropriate plan to regularly evaluate and closely monitor the individual for hemorrhoid bleeding, discomfort, or pain. Furthermore, the Facility did not consider internal hemorrhoids as a potential cause of the Individual's chronic constipation.<br>• Despite the known diagnosis of chronic, and acute, episodes of critical anemia, the Facility did not have a clinically appropriate plan in place for specific monitoring parameters. For example, the IRRF and IDT meeting minutes should include specific clinical parameters to monitor the Individual at least daily, until a diagnosis is confirmed and definitive treatment initiated; such additional monitoring should include regular assessment of vital signs, specific assessment and documentation for potential external blood loss, and specific assessment for possible pain, and discomfort, as well as periodic hemoccults, and gastroccults.<br>• Despite known chronic anemia, there was no documentation of a urinalysis being completed by the Facility, and when hospitalized the urinalysis indicated active bleeding. The etiology of the hematuria was presumed to be secondary to an underlying urinary tract infection (UTI); however, further testing indicated that the Individual did not have an active UTI. Regardless, chronic hematuria may, at times, result in chronic anemia, and the Facility should have been more closely assessing for hematuria, and its etiology.<br>• There was no documented evidence that the IDT had developed assertive and on-going care plans for the Individual's chronic anemia, chronic active gastritis, internal hemorrhoids, esophageal disorders including hiatal hernia, and esophagus stent with associated fluid pooling in the lower esophagus. In this particular case, because of potential life threatening blood loss, the IDT should have been meeting regularly, and reviewing all potential causes of blood loss, among the other conditions delineated above.<br><br>Summary:<br>The Monitoring Team determined that clinically important, and potentially serious medical conditions were not assertively managed by the Facility, and the IDT process did not appropriately represent important clinical issues.<br><br><u>Clinical Management of Recurrent Pneumonia</u><br>To assess the Facility's management of recurrent pneumonia, the Monitoring Team | |

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| | | reviewed:<br>• List of all individuals who experienced a diagnosis of pneumonia during the reporting period<br>• List of individuals who experienced a diagnosis of pneumonia during the reporting period, and who also experienced recurrent pneumonia, more than three episodes of pneumonia within the past five year<br>• For the five individuals who experienced the most numerous incidences of recurrent pneumonia from the list of those with recurrent pneumonia (#336, #305, #557, #499, and #66):<br>o Most recent annual medical summary<br>o Most recent IRRF<br>o Most Recent PT-OT assessment<br>o Current medication list<br>o Medical consultations, that specifically evaluate the individual to help mitigate recurrent pneumonia<br>o Most recent PNMT minutes<br><br>Incidence of pneumonia:<br>• The Facility provided a list of 53 individuals who experienced at least one episode of pneumonia, during the reporting period, for a total incidence of 73 cases of pneumonia occurring during the reporting period; and from that list, a total of eight individuals had experienced three or more episodes of pneumonia during the past five years.<br>• Of the 53 individuals who experienced pneumonia, 51 individuals (96%) were prescribed a special textured diet, or enteric tube feeding.<br>• Of the eight individuals with three or more episodes of pneumonia, six individuals (75%) were feed by enteric tube, and two (25%) were prescribed a special textured diet.<br>• For the eight individuals reported to have experienced recurrent pneumonia:<br>• Individual #499 experienced 18 incidences of pneumonia<br>• Individual #66 experienced 16 incidences of pneumonia<br>• Individual #336 experienced 12 incidences of pneumonia<br>• Individual #305 experienced 10 incidences of pneumonia<br>• Individual #551 experienced 9 incidences of pneumonia<br>• Individual #423 experienced 9 incidences of pneumonia<br>• Individual #351 experienced 8 incidences of pneumonia<br>• Individual #743 experienced 7 incidences of pneumonia<br><br>Physical Nutrition Management Committee Meeting (PNMC) Minutes regarding Pneumonia: | |

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| | | The Facility provided minutes from the PNMC, third quarter report, dated 10/17/2013. The committee tracked and trended three categories of pulmonary related infections, that included aspiration pneumonia, other pneumonia, and respiratory infections.<br><br>Type of pulmonary infection / 2012 Quarter 3 / 2013 Quarter 3<br>Respiratory infections / 44 / 19<br>Aspiration pneumonia / 5 / 9<br>Other pneumonia / 17 / 37<br><br>Respiratory infections included bronchitis, that required treatment with antibiotics, and there was no specific, clinically rational, criterion employed to distinguish between aspiration pneumonia and other pneumonia. Because many individuals with intellectual disability have known risk factors for aspiration pneumonia, and do not present with typical signs and symptoms of pneumonia, such as elevated temperature, elevated white blood cell count, auscultative features, or early signs of infiltrate on x-ray, the Monitoring Team raised significant concern with the Facility about its stratification of pneumonia, pneumonitis, and bronchitis. The Monitoring Team also raised concern over the Facilities tracking of bronchitis under the heading of "respiratory infections". Bronchitis, as with all pulmonary infections should be tracked independently from other respiratory infections, and not clustered with ear and sinus infections. Individuals who manifest signs and symptoms of bronchitis, may have an underlying pneumonia that had not manifested with the typical infiltrates seen in pneumonia.<br><br>The Monitoring Team also raised serious concerns with the Facility's analysis of pneumonia related data. The Facility indicated that the incidence of aspiration pneumonia had decreased; however, the incidence had increased from 2012 to 2013 (and especially from the last half of 2012, when there had been a reduction in incidence). The Facility provided a list of actions that had been taken between October 2012 and November 2013 to reduce incidence of pneumonia.<br><br>The Facility must revisit its process of tracking and trending all pulmonary related infections, including pneumonitis.<br><br>The following is a review of the Monitoring Team's findings from it's review of the last five individuals on the list of individuals with recurrent pneumonia (individuals #336, #305, #557, #499, #66):<br>1. The diagnosis of recurrent pneumonia was listed as a diagnosis on four out of five examples (80%).<br>2. A clinically rational medical action plan to help mitigate the recurrent | |

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| | | pneumonia was documented on the annual medical assessment in zero out of five examples (0%). The Monitoring Team noted that in three out of the five examples, there was a medical action plan documented; however, the action plan was not specific, nor did it address all necessary components of managing recurrent aspiration pneumonia.<br>3. There was documented evidence that the medical provider regularly assessed the individual for recurrent pneumonia, and to review and assess efficacy of prescribed supports and services for recurrent pneumonia, in zero out of five examples (0%).<br>4. In zero out of five examples (0%), the annual IDT clearly documented how recurrent pneumonia was impacting the individual's life, and the efficacy of all necessary supports and services to help reduce the incidence of pneumonia.<br>5. In zero out of five examples (0%), the IRRF clearly delineated all necessary supports and services to help mitigate the risks associated with recurrent pneumonia<br>6. In one out of five examples (20%), the annual OTPT assessment delineated a comprehensive assessment of recurrent aspiration pneumonia, and documented efficacy of all prescribed supports and services.<br><br>The following are some of the more serious issues identified by the Monitoring Team. Although not fully documented for Individuals #499, and #66, the Monitoring Team noted similar concerns as delineated for individuals #336, 305, and 551:<br>• Individual #336 was fed by enteric tube, and experienced a total of 12 episodes of pneumonia since 1/12/2011. The Facility determined that five episodes were related to aspiration, and seven episodes were secondary to other causes then aspiration. There was no clinical evidence provided, or observed on site by the Monitoring Team, that would lead to the exclusion of aspiration pneumonia for the seven episodes of pneumonia reported as "other causes" then aspiration. Furthermore, the Individual had significant underlying conditions that would contribute to aspiration pneumonia, rather then non-aspiration related pneumonia. Despite 12 episodes of pneumonia, recurrent pneumonia was not listed as a diagnosis on the most recent annual medical summary, also, there was no specific medical plan addressing recurrent pneumonia listed on the annual medical summary. Furthermore, the annual medical assessment plan had significant spelling omissions which made the action plan difficult to understand. In this case, as in the cases of all recurrent pneumonia a specific action plan that lists all necessary supports and services must be clearly delineated. In addition, there must be documented evidence indicating that the medical provider had assessed all prescribed supports and services, to ensure efficacy. The occupational therapy physical therapy assessment (OTPT) dated 10/23/2013 list risks associated with aspiration pneumonia, and outlined current physical | |

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| | | supports; however, the OTPT assessment stated "These supports and services have been effective as evidenced by observation, monitoring and chart review and should continue. (the Individual) did have one diagnosis of aspiration pneumonia this year which was hospital acquired". The Monitoring Team is very concerned with this assessment of supports and services, as data reviewed by the Monitoring Team noted that the Individual had four episodes of pneumonia during 2013, three of which were reported as "pneumonia" and one was reported as "aspiration pneumonia". Upon review of the active clinical record, available hospital records, and requested documents, the Monitoring Team could not find any specific clinical evidence that would support the diagnosis of community acquired pneumonia, over aspiration pneumonia. The Monitoring Team reviewed the physical nutritional management (PNMT) meeting minutes for the Individual. The PNMT documented that three out of the four cases on pneumonia were "bacterial" and not aspiration pneumonia, and hypothesized that the etiology of the recurrent bacterial pneumonia was because of poor hygiene issues, such as mouthing behavior. The Monitoring Team strongly recommends that the Facility revisit the clinical rationale for excluding aspiration pneumonia in all cases on pneumonia experienced by this Individual. The 11/8/2013 IRRF documented that aspiration was "well controlled in the last year AEB no aspiration issues". Also, the IRRF indicated that switching from enteral tube feeding to non-enteral tube feeding would not occur because of successful weight gain; and there was no comment of continued concern over aspiration risks.<br>• Individual #305 was fed by enteric tube, and experienced a total of ten episodes of pneumonia since 9/23/2010. The Facility determined that two episodes were related to aspiration and eight episodes were secondary to other causes then aspiration. There was no clinical evidence provided, or observed on site by the Monitoring Team, that would lead to the exclusion of aspiration pneumonia for the eight episodes of pneumonia reported as "other causes" then aspiration. Furthermore, the Individual had significant underlying conditions that would contribute to aspiration pneumonia, rather then non-aspiration related pneumonia. The current annual medical assessment did indicate recurrent aspiration pneumonia on the acute problem list, and there was a specific plan for aspiration pneumonia; however, did not address potential underlying medical causes of aspiration pneumonia, and there was no documentation in the annual medical assessment documenting the medical providers review of the efficacy of all prescribed supports and services to help mitigate aspiration pneumonia. The medical provider must regularly assess all prescribed supports and services. The most recent OTPT assessment documented a medical history from the year 2000 and there was no additional information about the more recent, and frequent episodes on pneumonia; for example, there were four reported | |

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| | | episodes of pneumonia documented in 2013, and the OTPT assessment did not address these episodes. The PNMT minutes for this Individual indicated a review of potential causes of pneumonia being increased residuals, and offered treatment recommendations to the medical provider; however, there was no discussion as to why the Facility did not categorize the Individual's pneumonia as aspiration pneumonia. The Most recent IRRF, which was dated 3/6/2013, indicated that the Individual was hospitalized for aspiration pneumonia on 7/11/2012, and 9/6/2012; however, there was no indication about other episodes of pneumonia that occurred on 9/18/2012, and 12/20/2012, and the IRRF was not updated to reflect three additional episodes on pneumonia that occurred in 2013. The IRRF documented "Dietician recommended that the team consider Peggy have intermittent enteral feeding (now on bolus feeding). This may reduce aspiration pneumonia". The Monitoring Team is concerned that the Facility offer recommendations on the IRRF, when the IRRF is intended to be a driving factor in the overall support of the individual, and must clearly delineate all necessary supports and services. The Monitoring Team could not identify any effort by the Facility to regularly assess functionality of all necessary supports and services to prevent aspiration pneumonia.<br>• Individual #551 was fed by enteric tube, and experienced a total of nine episodes of pneumonia since 11/8/2011. The Facility determined that six episodes were related to aspiration and two episodes were secondary to other causes then aspiration. There was no clinical evidence provided, or observed on site by the Monitoring Team, that would lead to the exclusion of aspiration pneumonia for the two episodes of pneumonia reported as "other causes" then aspiration. Furthermore, the Individual had significant underlying conditions that would contribute to aspiration pneumonia, rather then non-aspiration related pneumonia. The most recent annual medical assessment, dated 4/29/2013, did not describe, under the heading relevant medical problems, the three episodes of pneumonia that occurred during 2012 through the date of the annual medical assessment (2/21/2012, 9/14/2012, and 3/10/2013), and there was no addendum, or other more recent documentation by the medical provider indicating review of the incidence of pneumonia. The last major illness reported on the most recent annual medical assessment was that of a GI bleed in 2010. The Medical plan documented on the most recent annual medical assessment indicated that the probable cause of the recurrent pneumonia was most likely secondary to silent aspiration and dysphagia; however, there was no discussion or medical plan on what was done to help mitigate the risk of aspiration. For example, does the Individual have esophageal stricture, or hernia that might benefit by treatment. Also, the medical plan for pneumonia indicated that there was "no emesis prior to this incident" of pneumonia, however, under the medical plan for dysphagia, the plan documented that "Emesis still occurs but has been | |

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| | | greatly decreased overall". The medical plan also indicated that the pulmonologist recommended follow-up CT of the chest to be done during the summer of 2013. The Monitoring Team was not provided evidence that the CT was completed. The OTPT assessment, dated 3/15/2013, indicated that the Individual experienced 11 episodes of emesis during the previous year, and that the Individual had pulled out the enteric tube on 12 occasions; based on review of medical provider's IPNs, and quarterly assessments, neither of these issues were addressed by the medical provider. The annual OTPT assessment and the annual medical assessment documented results of a historic swallowing study, but there was no documentation that an esophagram had been completed, or a comment documenting that esophageal pathology was ruled out. Neither the annual medical assessment, or the OTPT assessment documented the efficacy of all prescribed supports and services. It is essential that the medical provider regularly assesses the efficacy of prescribed supports and services. The PNMT minutes for the Individual documented on 5/2/2013 that the Individual had only experienced two episodes of pneumonia between September 2012, and 5/2/2013, and determined that "the plans put in place by the IDT have been effective in mitigating (his/her) risk for aspiration pneumonia". The Monitoring Team is very concerned that the Facility determined that by having only two episodes of pneumonia, that required hospitalization, during a seven-month period, proves efficacy of an efficacious plan to reduce aspiration pneumonia. Following the 5/2/2013 PNMT meeting, the Individual had experienced an additional three episodes of pneumonia, through 10/6/2013 (6/9/2013, 7/15/2013, and 10/6/2013); hence, the Monitoring Team strongly recommends that the Facility review and revise its determination of efficacy for it treatment, and supports to help mitigate pneumonia. The Monitoring Team is very concerned with the assessment by the PMNT on 8/14/2013, that documented "due to (the Individual's) lungs (he/she) is going to be at increased risk for aspiration and will continue to have episode despite plan put in place by IDT. At this time PNMT no further assessment is needed by PNMT". The Monitoring Team has serious concerns with the PNMTs termination of management for recurrent pneumonia, as there were many potential clinical options to explore. Given that there was no specific evaluation of the esophagus, the PNMT may have consider further evaluation of the esophagus; there was no documentation of regular assessment of direct care staff's implementation of physical supports of the Individual; there was no evidence that specialists were involved in the assessment and management of recurrent emesis.<br>• Individual #499 was fed by enteric tube, and experienced a total of 18 episodes of pneumonia since 3/3/2009. The Facility determined that nine episodes were related to aspiration and nine episodes were secondary to other causes then aspiration. There was no clinical evidence provided, or observed on site by the | |

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| | | Monitoring Team, that would lead to the exclusion of aspiration pneumonia for the nine episodes of pneumonia reported as "other causes" then aspiration. Furthermore, the Individual had significant underlying conditions that would contribute to aspiration pneumonia, rather then non-aspiration related pneumonia.<br>• Individual #66 was fed by enteric tube, and experienced a total of 16 episodes of pneumonia since 2/27/2009. The Facility determined that three episodes were related to aspiration and 13 episodes were secondary to other causes then aspiration. There was no clinical evidence provided, or observed on site by the Monitoring Team, that would lead to the exclusion of aspiration pneumonia for the 13 episodes of pneumonia reported as "other causes" then aspiration. Furthermore, the Individual had significant underlying conditions that would contribute to aspiration pneumonia, rather then non-aspiration related pneumonia. The Monitoring Team noted that the most recent IRRF, dated 5/13/2013 indicated that "current supports appear to be effective as evidenced by no confirmed diagnosis of aspiration since 1/18/2013". The Monitoring Team is very concerned with the Facility's determination that the supports and services were effective, as the Individual had a total of five episodes of pneumonia in 2012, and as of 10/2013, an additional three episodes of pneumonia.<br><br>Summary:<br>The Monitoring Team has serious concerns with the Facility's overall management of pneumonia at the Facility. The Facility must immediately re-evaluate how it identifies and reports all pneumonia's, including aspiration, and potential aspiration related pneumonia, and pneumonitis. The Facility must ensure a more robust assessment of physical supports. The Facility must immediately ensure that all associate, and relevant underlying medical causes of aspiration are evaluated, and ensure that all potential treatments have been discussed within the context of the IDT. The IRRF must clearly delineate all necessary supports and services to help mitigate pneumonia.<br><br><u>Management of seizure disorder</u><br>To assess the Facility's ability to clinically manage seizure disorder, the Monitoring Team reviewed the following documentation:<br>• Alpha list of all individuals with diagnosed seizure disorder<br>• Alpha list of all individuals who experienced an episode of status epilepticus during the reporting period<br>• List of all individuals with diagnosis of intractable seizure disorder<br>• List of all individuals with implantable VNS<br>• For the first five individuals on the list of individuals with VNS, copy of the most | |

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| | | recent VNS interrogation report<br>• For all individuals diagnosed with intractable seizures.<br>o Annual medical summary<br>o Most recent two quarterly physician summaries<br>o Most recent two neurology consultation reports<br>o Current medication list<br>o Most recent EEG<br>o Most recent brain imaging report<br>o Current six months medical provider's IPNs, specific for management of seizure disorder<br>o IDT meeting minutes documenting supports and services necessary for the management of seizure disorder<br>o Seizure log<br><br>The Facility provided documentation listing 18 individuals having VNS placement. The Monitoring Team requested that the Facility provide a copy of the VNS interrogation report for the last five Individuals on the list (individuals #567, #674, #781, #262, and #251); however, the Facility only provided two of the five requested VNS reports (individuals #781, and #674). The VNS report for Individual #674 indicated that the unit was evaluated on 12/4/2013, and that the unit was activated by staff on 167 occasions. The VNS report for Individual #781 indicated that the unit was evaluated on 1/15/2014, and that staff had activated the unit on 13,704 occasions, and there was no associated documentation explaining the reason why the unit was activated on so many occasions; the Monitoring Team questions if seizure control had been adequately managed, if staff are using the device appropriately, or had the unit not been evaluated for a significant period of time. The Monitoring Team also has concerns that there was no VNS report for three of the five requested samples.<br><br>The following is the Monitoring Team's summary of its document review of seizure management for the last five individuals on the list of individuals who experienced an episode of status epilepticus, within the reporting period (individuals #170, #251, #43, #656, and #664):<br>• Five out of five example (100%) included an accurate DSM diagnosis for the seizure disorder.<br>• Four out of five example (80%) included a clinically appropriate medical action plan on the annual medical summary.<br>• Five out of five examples (100%) indicated that the Individual was regularly followed by neurology.<br>• Two out of five examples of individuals with implanted VNS (40%) had a current VNS interrogation report | |

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| | | • Three out of five examples (60%) included IPNs by the medical providers indicating clinically appropriate medical follow-up, following reported seizure activity.<br>• Two out of five examples (40%) had evidence indicating that an EEG was obtained within the past five years.<br>• In zero out of five examples (0%), the ISP included information documenting the type of seizure disorder, risks and benefits associated with treatment, prognosis of the seizure disorder, efficacy of treatment, and all necessary supports and services required for the management of seizure disorder.<br>• Three out of five examples (60%) were treated with two or less anticonvulsants. The Monitoring Team is aware that some Individuals with intellectual disability, who have been treated for seizure disorder for many years, and who may have structural brain damage, may require significant polypharmacy to control seizure disorder; however, the annual medical assessment, and the ISP must reflect the need for polypharmacy, and indicate any attempts at reducing polypharmacy in the past.<br><br>The following are some observations, comments, and concerns regarding the management of seizure disorder for individuals #170, #251, #42, and #656:<br>• Individual #170 was reported by the IDT addendum report dated 11/6/2013 indicated that the Individual had 26 reported seizures, and four hospitalizations related to seizure during the past year, and stated that the Individual was followed closely by a neurologist. The neurology consult report dated 12/18/2013 indicated that "seizure disorder stable", and to continue the current medications, with follow-up in one year. The most recent valproic acid level, documented on the neurology consult form was 65.1, which is towards the lower range for valproic acid; the most recent EEG report was dated 1991; and neuroimaging was reported to have never been completed. The Facility did not provide a copy of the seizure log, and there was only two medical provider's IPNs documenting follow-up to reported seizures. The Annual medical plan lacked comment on review of the seizure log, drug levels, and potential side effects and efficacy of current treatment. The annual ISP did not delineate how seizure disorder was impacting the Individual's life, and did not comment on the efficacy of supports and services provided for the management of seizure disorder. The IRRF dated 11/6/2013 indicated that the IDT was pursuing placement of a VNS, however, there was no neuro imaging or recent EEG to assist in determining the relevance of VNS placement, and the most recent neurology consultation report, dated 11/14/2013, did not comment on the IDTs discussion about the potential use of a VNS, once the Individual's infections had resolved. The 11/6/2013 IRRF commented that the Individual's increase in | |

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| | | infections may be causing increased seizures; however, there was no discussion about possible increased seizure causing the increase in pulmonary infections, or the possibility of antibiotics used to treat infections causing a decrease in anticonvulsant efficacy. There was also no evidence to indicate that drug levels were routinely obtained following seizures.<br>• Individual #251 has a diagnosis of Lennox-Gastaut Syndrome, which is known to cause severe, refractory seizures. The annual medical assessment, dated 10/2/2013 provided an exceptional review of the Individual's seizure disorder, under the heading "seizures" on page five of the assessment. The medical providers documented comprehensive reviews of laboratory drug monitoring of anticonvulsants, within the context of IPNs. There were examples of the medical provider following up on reported seizure activity, and the associated IPNs were in SOAP format, and clearly outlined the clinical issue. The Facility did not provide a copy of the seizure log, and there were no IDT minutes, or IRRF provided for review, despite the Individual being admitted in July of 2013.<br>• Individual #42 has a diagnosis of Lennox-Gastaut Syndrome, and has had frequent seizure episodes with resulting hospitalization. A IDT meet to develop an addendum to the PSP on 9/19/2013, following a hospitalization secondary to uncontrolled seizures. The focus of the IDT was on aspiration and dysphagia, and there was no discussion, or recommendations specific to seizure disorder. Per review of the attendance sheet, dated 9/18/2013, there was no physician present at the discussion. The only staff present was the QRDP, nurse, physical therapist, and building coordinator.<br>• Individual #656 has a diagnosis of partial complex seizure disorder. The annual medical summary, dated 10/15/2013 included an appropriate DSM diagnosis, a careful review of seizure data, and an effective medical plan for seizure disorder. There was evidence to support the medical provider's robust follow-up to active seizures. There was evidence of robust follow-up with a neurologist at the University Texas, South Western. The Facility did not provide a seizure log, annual ISP, or the most recent IRRF.<br><br>Summary:<br>Medical providers have continued to improve their follow-up and management of seizure disorder. The Facility must enhance its IDT process to better reflect on how seizure disorder impacts the Individuals lives, and document efficacy of supports and services necessary for the management of seizure disorder. The Facility indicated by written report that it does not utilize a seizure log. The Monitoring Team notes that other SSLCs use seizure graphs and logs to assist the medical providers, IDT, and consulting neurologists in better understanding seizure control; the Facility might consider implementing use of such a log or graph. | |

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| | | Management of end-of-life issues / do not resuscitate (DNR)<br>The Monitoring Team requested a list of all active DNR orders, and for the last ten individuals on the list, a copy of the most recent annual medical assessment, annual ISP, documentation by the medical provider documenting the qualifying conditionl and rationale for the DNR, and a copy of the current DNR order form, and ethics review. The following is a review of the five DNR examples provided.<br><br>Individual #220: On the list of individuals with DNR orders, indicated that the qualifying condition was congestive heart failure, however, the most recent annual medical assessment documented that the Individual had a history of congestive heart failure, indicating that his heart condition had stabilized. The annual medical assessment did not document a clinical rational for the DNR order. The most recent ISP indicated the "the team discussed the need for the Ethics Committee to meet and review the DNR status", and there was no comment on the IDTs understanding, or concurs with the DNR order. Review of the current out of hospital do not resuscitate order form indicated that the legal guardian did not complete the form by checking all appropriate boxes on the consent form, indicating the bases of the guardians agreement with the DNR order; also, the medical provider did not complete the physician's statement. The ethics committee had not rationally reviewed or approved the DNR order, and the most recent ethics review, dated 12/5/2013 indicated that "it is recommended that (the Individual's) DNR order be reviewed as a separate ethics committee meeting" to "review (the Individuals) current medical status to clarify qualifying conditions for continuing the DNR", and that "the DNR will remain in place until the ethics committee meets". The Monitoring Team has significant concern with the Individual's DNR order, that is tied to a diagnosis that is no longer active; no documented evidence of the medical providers review, and delineation of a qualifying condition; the medical provider not completing the DNR order form; and legal guardian not completing the DNR order form; and the lack of a meaningful ethics review. It should be noted that a medical provider's IPN was included for review, and dated 1/17/2014, which was after this document request. The IPN indicated that the medical provider would request that the "ethics committee review again the DNR that is in place"; the medical provider did not provide clinical rationale for the current DNR order.<br><br>Individual #92: The most recent annual medical assessment did not document the clinical rationale for the DNR order. A document entitle Monthly Review, and dated 7/10/2013, stated that the IDT would "arrange for the ethics committee to meet and review the DNR status". The most recent ethics review stated "there has been no request bye (the guardian) or IDT for a change in DNR statue. It is recommended that the DNR order remain in place given the following qualifying conditions: chronic lung disease, hypothyroidism, osteoporosis, severe spastic quadriplegia, osteoporosis". The legal | |

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| | | guardian did not fully complete the out of hospital do not resuscitate order form, by checking the most appropriate indication for the DNR. The Monitoring Team has significant concerns that there is no documentation providing clinical rationale for the DNR, that the guardian did not fully complete the DNR order form, and because of the lack of a meaningful review by the ethics committee. It should be noted that there was a medical provider's IPN was noted and dated 1/1/2014. The IPN did not document the clinical rationale for the DNR but only repeated the ethics committee's decision to continue the DNR, and several diagnosis, including "chronic lung disease, hypothyroidism, osteoporosis, sever spastic quadriplegia, osteoporosis". The Monitoring Team would like to point out that many people have diagnosis of hypothyroidism, quadriplegia, osteoporosis, and chronic lung disease, but do not meet a threshold for a DNR; the medical provider must clearly delineate the rationale why these conditions meet the threshold for a DNR.<br><br>Individual #365: The medical provider documented on the annual medical assessment that a no CPR order is in place "due to respiratory failure secondary to recurrent pneumonia, so her resuscitative status is no CPR". The Monitoring Team noted that the current active problem list documented on the most recent medical annual assessment did not include a diagnosis of respiratory failure, or recurrent pneumonia, and there was no medical action plan developed for "respiratory failure", or recurrent pneumonia, and the medical action plan did not list a DNR order, or other end of life planning issues. The most recent ISP indicated that a DNR was in place because of respiratory failure and recurrent pneumonia, and there was no comment by the IDT concurring with a DNR order. The ethics committee documented on 12/5/2013 that the Individual "would not be able to tolerate CPR. It is recommended that the DNR order (no chest compressions) remain in place due to the more harm would occur given the following conditions: Severe spastic quadriplegia, severe scoliosis, Barrett's esophagus, tracheostomy, tracheal diversion". The ethic's review did not include the same qualifying condition as noted on the ISP, or the annual medical assessment. There was a medical provider's IPN dated 1/1/2014 that recited the ethics review statement, including the same qualifying conditions stated by the ethics committee. The medical provider's IPN, or annual medical assessment, should clearly, and comprehensively document the specific clinical rationale for the DNR, and be used by the by the IDT, and ethics committee in determining the appropriateness of the DNR. In this case, a medical provider basically summarized the ethics committee's review; and it did not list the same qualifying conditions as noted in the ISP and annual medical assessment.<br><br>Individual #499: The annual medical assessment did not indicate the clinical rationale for the prescribed DNR order. The most recent ISP only stated "has a DNR in place", and did not comment on the clinical rationale for the DNR, nor its appropriateness. The ethics review, dated 12/5/2013 did not comment on the clinical rationale, and only | |

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| | | indicated that the Individual "would not be able to tolerate CPR", and listed a qualifying condition of "rotoscoliosis"; there was no diagnosis list, or medical action plan developed for rotoscoliosis, or even other forms of scoliosis. There were two ot of hospital do not resuscitate order forms provided for review. One of the forms was dated 2009, and was completed by two Facility medical providers; furthermore, the document was not completed appropriately. The second form was dated 12/26/2013, and was signed by the legal guardian, but was not completed by the medical provider.<br><br>Individual #336: The annual medical assessment and the most recent ISP did not document the clinical rationale for the DNR order. The most recent ethics review for the DNR, dated 12/5/2013, did not indicate a meaningful review for the need of a DNR order, and stated that the Individual "would not tolerate CPR" and listed the qualifying conditions of "osteoporosis, gastroparesis". The Monitoring Team has serious concerns over the lack of clear, and specific clinical rationale to support the continuation of a DNR order. A medical provider's IPN was provided, however, it was dated 1/17/2014, which was after this document request; furthermore, the IPN recited the ethics review commented from 12/5/2013. The most recent DNR order form was fully, and appropriately completed.<br><br>Summary:<br>The Monitoring Team has serious concerns with the Facility process for determining the appropriateness of DNR orders. All five examples lacked appropriate documentation of the underlying qualifying conditions, and in five out of the five examples, the medical provider, IDT, and ethics review committee had listed conflicting qualifying conditions. In three out of the five examples, the current out of hospital do not resuscitate form was not appropriately completed, and in the cases not signed by the medical provider, may not represent an active DNR order. The Facility did not provide evidence of instructions for direct care staff on how to proceed in the event of an end of life issue, hence, the Monitoring Team has concerns that direct care staff may not be well informed on how to manage an end of life issue for the individuals with DNR orders in place. The Facility must immediately address the Monitoring Team's concerns, with regard to its process for establishing qualifying conditions, documenting the clinical rationale for a DNR, and it's IDT and ethics review process. The Facility must also ensure that all DNR orders are completed appropriately.<br><br><u>Conclusion</u><br>The Monitoring Team noted significant areas of concern specific to medical provider's participation in interdisciplinary team meetings, and the morning medical meeting. The Facility was not ensuring that underlying causes of low bone mineral density was assessed, were not assessing efficacy of supports and services for the management of recurrent pneumonia, and were not routinely clinically assessing Individuals following | |

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| | | seizure activity. The Facility did not have an effective method of identifying and tracking aspiration related pulmonary events, such as aspiration pneumonia, and pneumonitis. Clinically relevant follow-up with prostate specific antigen monitoring were not obtained as clinically indicated, despite potential prostate pathology. In general, the Facility was not actively attempting to identify underlying causes of clinical issues, but merely treat overt manifestations. It is essential that all clinical conditions be evaluated for the underlying etiology of the condition, and that the IDT is well informed on all medical conditions, the etiology of medical conditions, how the condition impacts the life of the individuals, and all potential treatments, and associated risks and benefits of treatment, and of not providing treatment for a medical conditions. The Facility must also review, and enhance it's process of determining qualifying conditions for DNR orders, ensure that there is a meaningful ethics and IDT review for the DNR order, and that the DNR order form is appropriately completed. | |
| 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 facilitate the quality of medical care and clinical performance, the Monitoring Team requested the following information:<br>• Copy of all summaries, graphs and data for used for the external medical provider quality assurance audits.<br>• Documentation of all action plans.<br>• Documentation of follow-up of action plans through full implementation of the action plan.<br>• Documentation of assessment of the medical provider audits by the external physician reviewer.<br>• Statement from the medical director indicating that the results of the audit findings were personally discussed with each provider, and that the information was utilized within the context of peer review process.<br>• List of all indicators used to assess medical competency.<br><br><u>External Medical Provider Quality Assurance Audits</u><br>The Facility underwent round eight, of the external medical provider quality assurance audit, that was performed by a physician that does not work at the Facility, on August 16, 2013. The Monitoring Team was provided completed audit assessment forms for some of the medical providers at the Facility; however, the completed audit forms were purged of the medical providers identification, and there was no alternate means of separating out the audit forms from each other. Also, the Facility did not provide graphs and data forms that demonstrated comparison of each medical provider, by category of the medical provider quality assurance audit, or the medical management component of the medical provider quality assurance audit. The Facility did not provide a comprehensive list of corrective action plans developed for identified deficient items, or a list of the | Noncompliance |

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| | | status of each action plan. A statement by the external reviewing physician was not included for review. The QAQI meeting minutes, dated October 29, 2013, stated "Dr. Kubala met individually with each PCP to give performance feedback in the assessment of assessments.<br><br>The external medical provider audit includes a component called the medical management audit, which is intended to assess the medical providers clinical performance. For round eight, the medical management audit included a review of seizure disorder, urinary tract infections, and constipation. The Monitoring Team continues to have concern that the medical management questions do not address clinical competency of medical providers. The assessment should utilize a standardized tools to assess all medical providers equally, ensure that the assessment is specific for the medical provider being assessed, and compare the medical providers practice standards, to that of acceptable standard of care practice.<br><br>The current assessment tool did not ensure that the clinical issue being assessed were specific for the medical provider undergoing review. For example, the assessment tool relies purely on collection of data from the active clinical record, but it did not ensure that the medical provider under review was the medical provider who actually completed the activities, as documented in the clinical record, and being assessed by the assessment tool. In many cases, IPNs, completion of forms, and in some cases, medical orders, and review of laboratory date is completed by an on-call, or cross covering medical provider, and it is this work that is being attributed to the performance of the medical provider assigned to the case load.<br><br>The current assessments tools did not specifically address clinical outcome data, such as whether treatment was effective, or, if not, received appropriate additional diagnostic assessment and changes in treatment, nor did they , or determine if diagnostics, treatments, and follow-up adheres to standard of care practice. The following are some examples of the Monitoring Team's concern for the three clinical management issues assessed in round 8, of the medical provider quality assurance audit:<br>• Seizure disorder: There are six questions related to the clinical management of seizure disorder. Questions such as "seizures listed on the active problem list", Neurology consult obtained at least in the last 3 years", and Quarterly review of seizures documented by the PCP with recommendations", were included in the clinical management assessment for seizure disorder. In this example, there was no exploration if the actual ICD diagnosis for seizure was listed, or if the specific seizure disorder list was clinically appropriate, based on seizure manifestation, EEG results, and neuroimaging studies. Assessing if a neurology consult was obtained at least every three years is irrelevant if the individual has frequent seizures, side effects to anticonvulsant medications, requires VNS interrogation, | |

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| | | or is on polypharmacy that includes older, and more toxic anticonvulsants. The assessment did not determine if the medical provider reviewed seizure records to determine the status of seizure management.<br>• Constipation: The assessment tool questioned "is constipation listed on the active problem list", "did the provider prescribe the appropriate intervention", "is there evidence that the PCP documented follow up effectiveness of the treatment plan". In the example, there was no reference as to standard of care management for chronic constipation for people with complex intellectual and physical disabilities; the treatment for this population is different from that of the general population, due in part to health conditions common to this population and in part due to difficulties individuals have in communicating symptoms. There was no assessment to determine if the medical provider had determined the underlying etiology of the constipation. The Monitoring Team was pleased to see that the assessment determined if the medical provider assessed efficacy of treatment.<br>• Urinary tract infections: The assessment tool did not address recurrent urinary tract infections, and did not assess if the medical provider searched for the underlying condition leading to recurrent urinary tract infections; also, there was no assessment to determine if the medical provider utilized antibiograms specific to the individual and the Facility, when prescribing antibiotics.<br><br><u>Medical Management of the Assessment</u><br>The Facility developed and had started to implement a process called the medical management of the assessment. This process includes a physician that is external to the Facility to review one clinical record per month, for each of the eight medical providers. This review assesses the clinical efficacy of the annual medical assessment, and utilizes an assessment tool that is designed to assess the medical providers clinical performance. The Facility currently tracks the clinical performance for the treatment of 25 of the most frequently diagnosed medical conditions, including heart disease, pneumonia, metabolic syndrome, renal and muscular-skeletal conditions.<br><br>As discussed with the medical director, this process had yet to be fully implemented, and there was no tracking of completion or efficacy of action plans for deficient issues. The Monitoring Team will focus a closer review of this process one it is fully developed and formalized.<br><br><u>Conclusion</u><br>The Monitoring Team continues to have concerns that the external medical provider quality assurance audit process does not assess the medical providers clinical performance, and strongly recommends that the Facility review the audit tools, specific for this function. The audit tool should assess if the medical provider is performing at the | |

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| | | level of standard of care practice for medical conditions commonly identified in individual with complex physical and intellectual disabilities, and the assessment should ensure that it only assesses the medical provider that it is intended to assess. The Monitoring Team recognizes that the Facility has developed a new process call the medical assessment of the assessment, which employs an external physician as the reviewer; however, this process has not been fully implements, and there was no process to ensure tracking of action plans for deficient items. The Monitoring Team will comprehensively review this new process once it is fully implemented, and there is a mechanism to track and follow-up on all actions plans, systemic, and those developed for the medical provider. | |
| 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 utilizes clinical data and conducts trends analysis of clinical outcomes, the Monitoring Team:<br>• Discussed the Facility's medical quality assurance process with the clinical director<br>• Reviewed recent mortality cases with the mortality review committee<br>• Reviewed the policy for the mortality review process:<br>• Reviewed data, and reports for the Facility's internal medical provider quality assurance audit process<br><br>For its internal medical provider quality assurance audit process, the Facility utilized the same medical provider quality assurance audit process as the external medical provider review listed under Section L.2 of this report; however, instead of employing an external physician to review the medical providers, the Facility relied on physicians who were employees of the Facility. The Facility conducted round eight of the internal medical provider quality assurance audit on 11/26/2013, 11/14/2013, 8/16/2013, 8/15/2013, and 11/14/2013. As reported under Section L.2 of this report the Monitoring Team was provided completed audit assessment forms for some of the medical providers at the Facility; unfortunately, the completed audit forms were purged of the medical providers' identification, and there was no alternate means of separating out the audit forms from each other. Also, the Facility did not provide graphs and data forms that demonstrated comparison of each medical provider, and for each medical management issue assessed by the internal medical provider quality assurance audit. The Facility did not provide a comprehensive list of action plans developed for identified deficient items, or a list of the status of each action plan. A statement by the external reviewing physician was not included for review. The QAQI meeting minutes, dated October 29, 2013, stated "Dr. Kubala met individually with each PCP to give performance feedback in the assessment of assessments." Also, as delineated under Section L.2 of this report, the Monitoring Team could not interpret the provided graphs and data sheets. | Noncompliance |

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| | | Assessment of the Assessment<br>The Facility developed and had started to implement a process called the assessment of the assessment. The medical director informed the Monitoring Team that this process had not been fully developed or implemented, that there was no specific policy or procedure outlining the process (although there was an Assessment of Assessment policy), and specific action plans were not clearly developed or followed through to completion. As the Facility further develops this new system, the Monitoring Team will review this process more closely at future Settlement Agreement reviews.<br><br>It should be noted that the Monitoring Team was provided a significant amount of data and graphs, as part of the document request for Section L.3; however, the Monitoring Team could not interpret the data, or graphs, because graphs, and data lists were not clearly labeled or otherwise explained.<br><br>Health Services Compliance Audits<br>In addition to the internal medical reviews and Assessment of Assessments, the Health Services Compliance Coordinator/Auditor (HSCC) conducted audits and provided a number of graphs and tables for review.<br><br>Specific to the graphs provided for review, the Monitoring Team could not determine the specific nature of each graph, as they were not sufficiently labeled. For example, a graph titled "HSCC Audits, 2013 overall averages", did not explain what was meant by monthly overall averages, and the bar graph's x and y axes were not labeled. A second graph, titled "Integrated Morning Report Audit", did not explain what actually was being audited, and the x and y axes were not labeled. Another graph was labeled "Medical Provider Quality Assurance Audit, Essential and non-Essential Compliance by Provider, External Medical Management Audits for round 8"; this bar graph only delineated "essential compliance" and did not include non-essential compliance. Furthermore, the x and y axes were not labeled, and although the graph stated "by provider", and since there was only one bar, there was no indication that the graph was intended for a single medical provider, or if the graph represented collective, overall data, for all the medical providers. Another graph, titled "HSCC Audits, November Averages by Physicians", was an unlabeled bar graph, with a single bar representing each of the eight physicians; the y axis was not labeled, and it was unclear what was meant by "November Averages by Physician". As per previous reviews at the Facility, specific data, and data analysis, including a comprehensive list of all action plans, along with completion dates were provided for review; however, the Monitoring Team could not locate the same, or similar data forms, as provided in the past. The Monitoring Team will need to be provided data in a format that will enable the Monitoring Team to efficiently determine the following:<br>• X out of Y medical providers (Z%) received a score of 100% for essential | |

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| | | elements.<br>• X out of Y medical providers (Z%) received a score of 80% or greater for non-essential elements.<br>• X out of Y medical providers (Z%) received a score of 100% for medical management reviews.<br>• For the three medical management reviews<br>o UTIs had a cumulative score of x for all medical providers.<br>o Seizure had a cumulative score of X for all medical providers.<br>o Constipation had a cumulative score of X for all four medical providers.<br><br>It was obvious to the Monitoring Team that the Facility had spent a considerable amount of time and effort collecting and graphing all of the information provided, however, the Monitoring Team could not determine what the data represented. It will be helpful for the Facility to 1) ensure graphs are clearly labeled, and 2) review those in detail with the Monitoring Team at the next visit.<br><br><u>Data Based Quality Improvement Processes</u><br>Section L.3 requires that the Facility to develop a medical quality improvement process that collects data relating to the quality of medical services. A medical quality assurance process should include a process that looks at systems trends and outcomes of medical care. For example, the process should be looking at trends analysis of pneumonia, and addressing issues by developing system issues to help mitigate the incidences of pneumonia; systems issues may require the Facility to address performance issues of the medical provider, or providers. The Facility should be looking at many conditions (at least the top 20 of the most common and most serious conditions that affect individuals with complex disabilities. As part of this kind of system, the Facility should identify some clinical indicators of health status used for care of individuals with these common conditions that should be assessed for all individuals with specific diagnoses and aggregated to determine whether health care at the Facility is resulting in improved or stable health status system-wide, or whether specific healthcare issues need to be addressed. This should not only include measures of the occurrence of healthcare problems such as new instances of pneumonia or hospitalizations, but should also include measures that could lead to proactive treatment decisions prior to such instances and, at the same time, indicate trends in health status facility-wide, such as measures of HbA1c in individuals with diabetes.<br><br>As detailed in Provision H4, the Facility provided a table of QA key/clinical indicators that included many indicators of the efficacy of treatment and interventions. The table also included the months they were to be reviewed, the person responsible for the data and analysis, and the executive staff responsible for related CAPs and initiatives. Review | |

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| | | of QA/QI Council and PHMC minutes did not verify that all indicators were reviewed as indicated in the table (but the table did not indicate who was to do the reviews). For example, decubiti were to be reviewed monthly, but data were not included in the QA/QI Council documents for November 2013, December 2013, or January 2014.<br><br>The indicators on these lists included some used to address health status of individuals with chronic conditions in a proactive manner. However, system-wide review focused on occurrences of undesirable outcomes, such as hospitalizations and emergency room visits, instances of pneumonia, and falls. The Diabetes Management report to the PNMC did include some measures useful for tracking individuals' status.<br><br>Mortality Review<br>To assess the Facility's ability to conduct clinically meaningful mortality reviews, the Monitoring Team reviewed all recent deaths, along with the mortality review committee members, and the Facility recent death review protocol. The following is an overview of the Monitoring Teams findings, and recommendations.<br><br>New/Revised Policies, Procedures, Protocols, and Processes: The Facility's Clinical Death Review Committee and Administrative Death Review Committee Policies had not been updated since 2006. In an effort to improve the death review process, the Facility had developed and implemented Exhibit A – Quality Assurance Death Review Protocol to the DSSLC Medical 07 – Death of an Individual Policy, 12/1/13. The purpose was to provide a documented protocol for the Quality Assurance Death Review process completed by an external physician following the death of an individual.<br><br>As found in previous reviews the Texas Department of Aging and Disability's Death Review Policy had not been updated. When the State Office Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care.<br><br>Training: Exhibit A related to the policy on Medical Care was not a change in process, but was instead a delineation of the current process. As a result, the policy was disseminated as a reference tool, placed in the Policy folder, but additional training was not required.<br><br>Clinical and Administrative Death Review Committees: Since the last compliance review, as recommended, the Clinical Death Review Committee membership had been expanded to include relevant clinical disciplines and other support staff responsible for the specific residential area where the deceased individuals lived. The membership included but was not limited to the following staff: Medical Director, Staff Physicians/Family Nurse Practitioners, Outside Physician, Visiting Physician via conference call, Chief Nurse | |

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| | | Executive, Nursing Operating Officer, Nurse Investigator, Compliance Nurse, RN Case Manager Supervisor, RN Case Manager, Quality Assurance Nurse, Staff RN, Infection Control Nurse, Hospital Liaison Nurse, and other disciplines/program support staff when indicated, i.e., Habilitation Director/designee.<br><br>The Administrative Death Review Committee membership had also been expanded to include: Facility Director, Medical Director/Administrator, Chief Nurse Executive, Nursing Operating Officer, Nurse Investigator, Outside Representative, Quality Assurance Representative, Assistant Director of Programs, and other administrative staff when indicated.<br><br><u>Monitoring Team's Independent Review of Deaths:</u> Since the last compliance review, July 2013, three deaths had occurred; in addition, two individuals had died during the last review. Clinical and Administrative Death Review Committee Meetings had been completed for these deaths. The weekend prior the Monitoring Team's arrival, three deaths had occurred and during the week of the compliance review another death occurred. These four recent deaths will be reviewed at the next compliance review.<br><br>General findings of the five deaths reviewed included:<br>• Of the five deaths reviewed, the average age was 57.8 years (ages varied from 52 to 65 years of age).<br>• Two of five (40%) deaths had an autopsy completed. (Individuals #750 and #443)<br>• Three of five (40%) decedents received enteral nutrition via G-Tube feedings. (Individuals #769, #750, and #575)<br>• Zero of five (0%) were reported as unusual deaths.<br>• Five of five (100%) had Unusual Incident Reports (UIRs) completed related to the deaths.<br>• Four of five (80%) deaths occurred at a hospital. One death occurred at the Facility.<br>• Four of five (80%) decedents had Do Not Resuscitate (DNR) status for full code prior to death. One decedent's DNR status was reported as not determined at the time of death.<br>• The cause of five individuals' deaths, as listed on the Death Certificates, are listed in the chart below:<br>1. Individual #750:<br>Immediate Cause of Death: Probable Acute Myocardial Infarction<br>2. Individual #575:<br>Immediate Cause of Death: Multi Organ Failure Secondary to Unknown Malignancy<br>Underlying Cause of Death: Pulmonary Nodules of Unknown Origin | |

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| | | 3. Individual #443:<br>Immediate Cause of Death: Aortic Stenosis<br>Underlying Causes of Death: Aortic Bicuspid Valve<br>4. Individual #710:<br>Immediate Cause of Death: Pneumonia<br>Underlying Causes of Death: Sepsis<br>5. Individual #769:<br>Immediate Cause of Death: Pneumonia<br>Underlying Causes of Death: Sepsis<br><br>• Upon review and discussing each of the five cases with members of the Mortality Review Committee, the Monitoring Team determined that the Facility did not adequately review contributing factors, and possible contributing factors that ultimately lead, or possibly contributed to, the deaths of the individuals. During the meeting with the Mortality Review Committee, the Monitoring Team raised specific concerns with the level of review for each death, and the concerns were concurred by each member of the Mortality Review Committee member that was in attendance.<br>• The Nurse Investigator continued to maintain a Death Review Compliance Report tracking system for compliance with the Facility's Clinical and Administrative Death Reviews Committee Policies. A review of the report found that policies were followed for five of five (100%) of deaths reviewed.<br>• A review of Clinical and Administrative Death Review Committees' minutes, supporting documentation, and Recommendation Tracking Logs for each death showed that five of five (100%) contained recommendations that had been completed, although some recommendations were not completed in accord with the established due dates.<br><br>Based on the Monitoring Team's independent review of the Clinical Death Review Committees' recommendations, several problematic issues were identified:<br>• Recommendation actions from the URI Reports for Individuals # 443 and # 710 were not included:<br>o Individual #443: The URI Report stated, "Additional drills will be held with staff regarding utilizing the back board in bed."<br>o Individual #710: The URI Report stated, "It is recommended that staff members in Apartment 504B be in-serviced to notify nursing personnel when they notice any changes in an individual's usual behavior or routine."<br>These recommendations should have been considered and/or included by the Clinical Death Review Committees.<br>• Recommendations were often statements as opposed to a recommendation that stated specific desired actions to be taken that were measureable and could be | |

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| | | tracked through to resolution.<br>• The Facility should ensure that recommendations are completed by the established due date for completion. If recommendations cannot be completed by the established due date, there should be a statement included to justify the delay in completion.<br><br>The Monitoring Team remains very concerned that the mortality review process does not adequately assess historic level of clinical care, and other supports such as physical and nutritional management, when assessing the cause, potential cause, and contributing factors, of the death of individuals; and because such issues were not assessed, relevant action plans to enhance level of care at the Facility was not adequate. The Monitoring Team strongly encourages the Facility to immediately enhance its mortality review process.<br><br>Conclusion:<br>The Facility had recently developed a new process to assess medical quality assurance at the Facility, called the assessment of the assessment. This process had yet to be fully implemented, and required formalization. The Monitoring Team will conduct a comprehensive review of this process at subsequent Settlement Agreement reviews. This new process was outlined by Facility's medical director, and the Monitoring Team believes that this new process may enhance the Facility's medical quality assurance process. The internal medical provider quality assurance audit process did not provide an effective means to assess clinical outcomes; Section L.2, of this report provides details of concerns and comments regarding the medical providers quality assurance audit process. Section L.3 requires that the Facility to develop a medical quality improvement process that collects data relating to the quality of medical services. A medical quality assurance process should include a process that looks at systems trends and outcomes of medical care for common and/or serious conditions. As part of this kind of system, the Facility should include some clinical indicators of health status used for care of individuals and aggregated system-wide, in addition to data on outcomes.<br><br>The Monitoring Team has serious concerns with the lack of a comprehensive review of historical level of care that resulted in the death, contributed to the cause of death, or possibly contributed to the cause of death of individuals. The Monitoring Team provided members of the Mortality Review Committee with specific examples, and concerns by the Monitoring Team. | |
| L4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 | 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 | Noncompliance |

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| | 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. | policies for medical care, and the Monitoring Team was provided:<br>• DADS Medical Care Policy: 009.2, dated 5/15/2013,<br>• DSSLC Policy Med- 1; Medical Quality Assurance, dated 7/1/13<br>• DSSLC Integration of Clinical Services Policy: CMGMT 03, dated 12/1/2013<br><br>The Monitoring Team was informed by the medical director that the Facility had not updated its medical policy since the previous compliance visit. The Monitoring Team reviewed the DSSLC Policy Medical 01, dated July 1, 2013, from the previous compliance visit and noted that the DSSLC medical policy, dated 5/15/2013, had been updated to incorporate policy directives from the DADS Medical Care Policy. The Monitoring Team noted, for several areas of the DADS Medical Policy, medical providers were not adhering to the policy. The following is a list of some concerns of medical providers not following the DADS Medical Policy. Based on review of active clinical records and documents for Section L.1, of this report, the Monitoring Team noted the following concerns:<br>• Medical providers not following up daily on acute issues until stabilized or resolved, such as cases of pneumonia, and exacerbation of seizure disorder.<br>• Per review of quarterly assessment, medical providers did not review all active conditions each quarter.<br>• Medical providers were not assertively attempting to help minimize the risk of recurrence or exacerbation of a medical condition. This was especially evident by the review of pneumonia, seizure disorder, and osteoporosis. In these cases, there was not consistently assessment by the medical provider to determine underlying etiology.<br>• Medical orders did not list monitoring parameters, and what changes needed to be brought to the attention of the PCP. It is absolutely essential that the medical provider ensure that specific monitoring parameters be well documented, and ordered, for all medical conditions, especially acute issues, such as active seizures, and pneumonia, and worsening constipation.<br><br>During discussion about clinical policies and procedures, with the medical director, the medical director informed the Monitoring Team that the Facility had yet to develop and implement all necessary policies and procedures for clinical operations at the Facility. By review of the current DSSLC Medical Policy, the Monitoring Team determined that the Facility did not have policies and procedures to address all relevant clinical activities. For example:<br>• There was no reference to indicating the need to use antibiotic biogram when selecting antibiotics to treat pneumonia and other conditions.<br>• There was no documented expectation on the frequency and comprehensiveness of follow-up for chronic medical conditions, such as diabetes, hypertension, constipation, and recurrent pneumonia. For this | |

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| | | example, clinically appropriate pathways should be developed that clearly delineate practice standards, and the policy should refer to the pathway.<br>• Because the policy had not been fully implemented by the medical department, the Monitoring Team did not assess the DSSLC Policy Med- 1; Medical Quality Assurance, dated 7/1/13, at this compliance visit.<br><br>Summary:<br>The Facility had yet to develop and implement all necessary policies and procedure necessary for clinical operations. It is essential that a medical facility have updated policies and procedures that clearly delineate all aspects of clinical, and clinical-administrative activities, and implement such policies.<br><br>Conclusion:<br>The Monitoring Team has serious concerns over medical services at the Facility. Follow-up through full resolution of medical issues; exploring underlying etiology of medical conditions; assertive, and meaningful participation by medical providers within the context of the interdisciplinary team process; conducting efficacious assessment of performance standards of medical providers; ensuring a process that effectively determines the quality of medical services by collecting sound clinical data, analyzing the data, and developing and following up on effective action plans; developing, implementing and updating medical policies and procedures that delineate all areas of clinical, and clinical-administration activities; and ensuring a robust mortality review process, were some of the areas observed by the Monitoring Team to be deficient. | |

| SECTION M: Nursing Care | |
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| Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Section M Self-Assessment, Updated: 12/27/13<br>2. DSSLC Section M Action Plans, Updated: 12/5/13<br>3. DSSLC Section M Presentation Book<br>4. DADS State Supported Living Centers Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Date: September 2013<br>5. DADS State Supported Living Centers Nursing Protocol: Enteral Medication Administration, Revised: December 2013<br>6. DSSLC Guidelines: Infection Control Processes: Real Time Infection Control Note/Real Time Audit, 8/1/13<br>7. DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy – 27.1, Revised: 11/10/13<br>8. DSSLC Nursing: Infection Prevention and Control, Revised 10/22/13<br>9. DSSLC Protocol for Suspected or Confirmed Bed Bug Infestation, 12/13/13<br>10. DSSLC Antibiogram Procedure, no date<br>11. DSSLC Handwashing Surveillance Procedure, no date<br>12. DSSLC Hygiena System Sure Plus ATP Monitoring Swab Procedure, no date<br>13. DSSLC Pandemic Respiratory Infectious Disease Readiness Plan, Reviewed 10/22/13<br>14. DSSLC Risk Action Plan and Clinical Indicators/Data Considerations, no date<br>15. DSSLC Campus Map<br>16. DSSLC Nursing Organizational Chart<br>17. DSSLC Nursing Education Monthly Summaries, July 2013 through December 2013<br>18. DSSLC Annual Nurse Competency Training Tracking Spreadsheets for past year<br>19. DSSLC Nursing Standardized Procedures-Protocol-Guidelines Training Tracking Spreadsheet, to date<br>20. DSSLC Supplemental Nurses Training Tracking Spreadsheet, 7/1/13 through 12/31/13<br>21. DSSLC Nursing Monthly Staffing Patterns for all Units and Infirmary, July 2013 through December 2013<br>22. DSSLC Summary/Analysis of Nursing Monthly Staffing Report for all Units and Infirmary, July 2013 through December 2013<br>23. DSSLC Number of Nursing Positions Budgeted, Filled, and Unfilled, to date<br>24. DSSLC RN Case Manager Roster<br>25. DSSLC Nursing Monthly Overtime Hours Report, July 2013 through October 2013<br>26. DSSLC Nursing Monthly Schedule for all Units and Infirmary and for all shifts, November 2013<br>27. DSSLC Nursing Meeting Schedule Week of January 13 through January 17, 2014<br>28. DSSLC Nursing Unit Meetings, 7/31/13 through 11/22/13<br>29. DSSLC Nursing Compliance Meeting Minutes, 10/29/13 and 11/15/13<br>30. DSSLC QA/QI Council Meeting Minutes, 8/26/13, 9/24/13, 10/29/13, 11/19/13, 12/26/13, and 1/9/14<br>31. DSSLC Nursing Administration's Review of QA/QI Report Meeting Notes, August 2013<br>32. DSSLD Monthly Physical and Nutritional Management Committee Meeting Minutes, June 2013 through December 2013<br>33. DSSLC Nursing Corrective Action Plans (CAPS) for the past six months |

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| | 34. DSSLC Pharmacy and Therapeutics Committee Minutes September 2013 through January 2014<br>35. DSSLC Pre-Medication Variance Committee Minutes for the past six months<br>36. DSSLC Medication Variance Committee Minutes for the past three months<br>37. DSSLC Medication Variance Data, July 2013 through December 2013<br>38. DSSLC Medication Administration Observation Data June 2013 through November 2013<br>39. DSSLC List of Emergency Response Committee Membership<br>40. DSSLC Emergency Response Committee Meetings, September 23, 2013 and December 19, 2013<br>41. DSSLC Summary of Review of Emergency Equipment, July 2013 through November 2013<br>42. DSSLC List of Facility Emergency Equipment and Automated External Defibrillators Locations<br>43. DSSLC List of Staff Responsible for Conducting. Reporting, and Tracking Mock Medical Emergency Drills<br>44. DSSLC Mock Medical Emergency Drill Data, January 2013 through December 2013<br>45. DSSLC Incident Management Review Team (IMRT) Meeting Notes/Logs for past six months<br>46. DSSLC CDT Course Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) Basic and CPR for Healthcare Providers, Printed 12/5/13<br>47. DSSLC Monthly Antibiograms for the past six months<br>48. DSSLC Infection Control Curricula and Training Materials<br>49. DSSLC CDT Course Due/Delinquent List for Infection Control, Printed 12/9/13<br>50. DSSLC Percentage of Individuals' Current with Flu Vaccinations<br>51. DSSLC Percentage of Individuals' Current with Tuberculosis (TB) Skin Testing and Follow-up on Individuals With TB Skin Testing Conversion<br>52. DSSLC Percentage of Employees Current with Flu Vaccinations<br>53. DSSLC Percentage of Employees Current with Tuberculosis (TB) Skin Testing and Follow-up on Individuals With TB Skin Testing Conversion<br>54. DSSLC Percentage of Employees' Vaccinated with Hepatitis B Series<br>55. DSSLC Integrated Morning Report Minutes, 1/6/14 through 1/15/14<br>56. DSSLC Infirmary Admission for the past year<br>57. DSSLC Facility Health Risk Data for Individuals<br>58. Sample Review of Comprehensive Records for 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 13 Individuals: #519, #326, #187, #243, #800, #286, #668, #616, #425, #28, #459, #666, #583<br>59. Sample Review of Community Placement Nursing Summaries and Discharge Packets for five Individuals: #611, #171, #686, #320, #238<br>60. Sample Review of Records of five Individuals with Recent and/or Active Decubitus Ulcers. Individuals included: #423, #187, #286, #86, and #129.<br>61. Sample Review of Ten Most Recent Reported Medication Variance Reports for Individuals: #695, #752, #214, #760, #336, #483, #781, #628, #497, #742<br>62. Sample Review of Records of Five Active Urinary Tract Infections for Individuals: #668, #28, #187, #507, #612<br>63. Sample Review of Reports of Five Reportable Infectious/Communicable Diseases for Individuals: #32, #719, #218, #86, #587 |

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| | 64. Sample Review of Four Hospital Records for Currently Hospitalized Individuals: #590, #606, #105, #336.<br>**People Interviewed:**<br>1. Delia Schilder, RN, Chief Nurse Executive (CNE)<br>2. Sherri Courtney, RN, Nursing Operations Officer (NOO)<br>3. Sibylle Graviett, RN, Compliance RN<br>4. Diane Porter, RN, RN Case Manager Supervisor<br>5. Sharon Lancaster, RN, Hospital Liaison Nurse<br>6. Amber Shotts, RN, Hospital Liaison Nurse<br>7. Calista Aston, RN, Skin Integrity Nurse/Wound Care/Educator<br>8. Maria Palenzuela, RN, Infection Control Preventionist (ICP)<br>9. Linda Barnett, RN, Nurse Educator<br>10. Gwen Weiss, RN, Nurse Educator<br>11. Susan Hyde, RN, Nurse Manager, Cedar Falls<br>12. Penny Dibley, RN, Nurse Manager, Houston Park<br>13. Hilda Clemente, RN, Nurse Manager, Eastfield and Pine Ridge<br>14. Dawn Jones, RN, Nurse Manager, Eastfield and Timberhill<br>15. Traci Carroll, RN, Nurse Manager, Infirmary<br>16. Elizabeth Ward, RN, Nurse Manager, 10-6 Shift<br>17. Mary Harrison, RN, Quality Assurance Nurse<br>18. Sara West, RN, RN Case Manager, Cedar Falls<br>19. Karen Hibbard, RN, RN Case Manager, Cedar Falls<br>20. Sara O'Bryan, Lead QIDP, QA Auditor for Section I<br>21. Linda Wilson, QIDP, QA Auditor for Section I<br>22. Ernest Reinhold, QIPD, Cedar Falls<br>23. Numerous Other RN Case Managers, RNs, and LVN Staff Nurses<br>**Meetings Attended/Observations:**<br>1. Review of Section M Presentation with Nursing Leadership, 1/13/14<br>2. Critical Incident Review for Individual #719, 1/13/14<br>3. ISP Meeting for Individual #567, 1/13/14<br>4. Medication Administration Observations and Tour in Cedar Falls, 1/13/14<br>5. Pharmacy and Therapeutic Committee Meeting, 1/14/14<br>6. Admissions and Training Committee Meeting, 1/14/14<br>7. Meeting with Emergency Response Lead Staff: Deborah Salsman, Risk Management Director, Allan Garrison, Quality Assurance Nurse Supervisor, David Anderson, Safety Specialist, CNE, and NOO, 1/14/14<br>8. Unit Observations with Skin Integrity Nurse, 1/14/14<br>9. Medication Administration Observations and Tour in Houston Park, 1/14/14<br>10. Integrated Morning Meeting/Report, 1/15/14<br>11. Medication Variance Committee Meeting, 1/15/14<br>12. Death Review Meeting with Medical Director, Nurse Investigator, Health Service Compliance Officer, CNE, NOO, and RN Case Manager Supervisor, 1/16/14 |

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| | 13. Physical Nutritional Management Committee (PNMC) Meeting, 1/16/14<br>14. Meeting with QA Nurse for Section M and QA Monitors for Section I, 1/16/14<br>15. IDT Meeting for Individual #243, 1/16/14<br>16. IDT Meeting for Individual #567, 1/16/14<br>17. Daily Meetings with Various Nursing Leadership |
| | **Facility Self-Assessment:**<br>For Section M, in conducting its Self-Assessment, the Facility:<br>• 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 of nursing over time and agency nursing hours, infection control, skin integrity, emergency response, nursing monitoring tools, medication variances, along with narrative explanations for items assessed for each Provision. These data provided sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>• The data reported included sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes.<br>• The Self-Assessment identified the sample(s) sizes.<br>• 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 Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, RN Nurse Case Manager Supervisor, Specialty Nurses, Nurse Managers, and Quality Assurance Nurses.<br>• 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).<br>• Sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the Medication Administration Observation Tools. Inter-rater reliability for Nursing Care Monitoring/Audit Tools was in process.<br>• 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, infection control reports, number of pressure ulcers, and medication variance data.<br>• The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment:<br>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.<br>o Consistently measured the quality as well as presence of items.<br>o Distinguished data collected by the QA Department versus the Nursing Department.<br>• 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. |

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| | **Summary of Monitor's Assessment:**<br>Provisions M.4 and M.6 were found in substantial compliance. Provisions M.1, M2, M.3, and M.5 were not found in substantial compliance. For Provisions M.1, M.2, M.3, and M.5 there was evidence that processes were in place for continued improvement, which showed promise in moving these Provisions forward toward substantial compliance, as reflected in the report.<br><br>Provision M.1 contained multiple requirements. If the requirements for Hospital Liaison Nurses, Infection Control Program, 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. Nursing Administration was in the process of updating and refining Nursing Protocol Card Monitoring Tools and the Inter-rater Reliability Processes, which should result in improved outcome of audits, as reflected in the report.<br><br>Provision M.2 showed that the Nursing Department had recently adopted, implemented, and trained the RN Case Managers on the state's standardized Nursing Assessment Form and Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. Nursing Administration was in the process of updating and refining Annual Nursing Assessment Monitoring Tool and the Inter-rater Reliability Process, which should result in improved outcome of audits, as reflected in the report.<br><br>Provision M.3 showed the Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance, as reflected in the report.<br><br>Provisions 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 review of training records that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed, as reflected in the report. The Facility nursing audits did not yet provide information on implementation of protocols; these were revised, and this information will be reviewed at the next compliance visit. Furthermore, a death had occurred that led to questions about whether a protocol was followed; information to make a determination was not available at the time of this report and will be reviewed at the next compliance visit.<br><br>Provision M.5 showed the Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. Recently the Facility developed, implemented, and trained the Interdisciplinary Teams (IDTs) on Risk Action Plan and Clinical Indicators/Data Considerations, which should assist the IDTs in ensuring that all relevant clinical data are considered in make risk rating decisions. The Facility recently formed a work group to address participation in the ISP, IRRF, and IHCP processes. However, these processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance, as reflected in the report. |

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| | Provision M.6 showed continued substantial compliance with all aspects of medication administration practice according to current generally accepted standards of practice. The Facility continued to maintain robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances, as reflected in the report. |

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| M1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status. | <u>Monitoring Team's Findings:</u><br>The Facility's Provision M.1 Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Through review of Section M Self-Assessment, Section M Presentation Book, staff interviews, observations, and review of documents, there was evidence that the Nursing Department showed progress made 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, action plans, and findings upon which they based their status of compliance.<br><br>This Provision of the Settlement Agreement includes a number of requirements that address various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding nursing assessments, development, and implementation of nursing protocols and health care plans is found below in Provisions M.2, M.3, M.4, and M.5 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.<br><br><u>Staffing:</u><br>At the time of the compliance review, DSSLC had a census of 469 individuals. Since the last compliance review, DSSLC had a total allocation of 220.3 nursing positions, of which 109.5 RN positions were filled and 83.4 LVNs were filled. Four of the RN positions were allocated to other departments, i.e., two RNs to the QA Department, one RN to the Habilitation Department, and one RN to the Risk Management Department. The Chief Nurse Executive (CNE) and Nursing Operation Officer (NOO) were not included in the total allocation of nursing positions. All Nursing Administrative, Management, and Specialty positions were filled. Over the past six months, six of 28 (22%) RN Case Managers had resigned, but vacant positions had been filled. Despite some vacancies, primarily for direct care nurses, overall the Nursing Department had remained relatively stable.<br><br>The Nursing Administration, Management, and Specialty Nurses continued to remain 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 | Noncompliance |

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| | | 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 a change in the Nurse Manager position for Houston Park. The change was made through promotion of an incumbent RN Case Manager: The promotion to higher level nursing position 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. Refer to information reported below in this Provision related to specialty areas of nursing practice.<br><br>The Nursing Department continued to monitor nursing staffing patterns and established nursing ratios for the Units and Infirmary daily on each shift. Staffing 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 Supervisors to review staffing and assist with covering Units when needed by sending nurses from over-covered areas to areas of need. Staffing patterns and ratio data were analyzed and reported monthly, as well as overall for the last six months.<br><br>The analysis of staffing data, July 2013 through November 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/analyze staffing ratios as changes occurred in population, acuity, and logistics per Unit. There was evidence through interview with the nursing administration/management that results of the analysis were used for decision-making in arranging staffing coverage. 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.<br><br>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 July 2013 through November 2013, staffing ratios were met consistently at the "least" acceptable staffing numbers. Nursing Administration continued to monitor monthly the use of overtime and contract agency hours. The Nursing Department continued to actively recruit nursing personnel. When possible, employment fairs were attended by key nursing personnel, i.e., DSSLC Second Annual On-Campus Job Fair, 10/30/13, and advertisement in the Texas Nurses Association (TNA) Quarterly Publications. 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/skills during their orientation period. In addition, the CNE and NOO had begun exploring the potential for the 6-2 shift nurses to receive differential pay for working 2-10 and/or 10-6 shifts. If the pay differential was achieved it could potentially assist with retention.<br><br>As was reported in the Self-Assessment, the CNE, NOO, and RN Case Manager Supervisor attended the | |

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| | | weekly Admission and Training Meeting. As coverage needs for RN Case Managers or floor nurses were identified in the meeting, they shared this information with the appropriate Nurse Managers. The RN Case Manager Supervisor also evaluates the needs for RN Case Managers and updates the RN Case Manager Roster periodically. In an interview with the CNE, the caseload size of the RN Case Managers was discussed. Due the number of individuals with high risk rating factors, for RN Case Managers who have an excess of 18 or more individuals the CNE was evaluating ways to reduce those caseloads with existing nursing resources. The Monitoring Team attended the Weekly Admission and Training Meeting with the CNE on 1/14/14. From the applicants reviewed for admission to the Facility with high risk health and behavior concerns coupled with the existing Facility individuals with high risk rating and complex medical and behavioral needs, consideration should be made to add additional RN Case Manager positions to ensure individuals' health and behavioral needs are sufficiently met as required.<br><br>The Monitoring Team's review of Nursing Meeting Minutes since the last review showed that meetings continued to be conducted routinely, at least monthly by Nursing Administration, Nurse Managers and/or RN Case Manager Supervisors. The minutes were substantive in content, which kept the nursing staff up-to-date on relevant issues, including issues that needed continued improvement, i.e., 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.<br><br>It was positive for the Monitoring Team to find that each management and specialty nurse continued to have comprehensive and detailed job descriptions of their respective nursing responsibilities/duties in relation to Facility priorities and each respective responsibility/duty was correlated with specific Provisions of Section M of the Settlement Agreement.<br><br><u>Quality Assurance Efforts:</u><br>Since the last compliance review, the Nursing Department continued to refine the Section M monitoring process by adopting state office guidelines for Quality Assurance/Compliance Standards. The monitoring process currently in place as reported in the Self-Assessment and through the Monitoring Team's independent interviews, review of documents, and monitoring data, is described below:<br>• Of the 23 nursing protocol cards audit tools developed by the state office, the Nursing Department used the following protocol card audit tools:<br>• Vomiting<br>• Urinary Tract Infections (UTIs)<br>• Antibiotic Therapy<br>• Seizure Activity<br>• Status Epilepticus<br>• PICA Episodes<br>• Respiratory Distress/Aspiration<br>• Documentation of Pre-Treatment and Post Sedation<br>The revised/updated monitoring tools listed below began use in September 2013. | |

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- Urgent Care/ER Visits/Hospitalizations
- Infection Control Real Time Monitoring/Infection Control
- Annual Nursing Assessments

<u>Nursing Staff Responsible for Monitoring and Monitoring Process:</u>

- As assigned by the QA department, the Nurse Managers continued to complete two tools for each per month of the protocol audit tools, unless there were no incidents for particular protocols.
- The Hospital Liaison Nurses and Infirmary Director completed a total of five Hospitalization/Urgent Care/ER Visit monitoring tools per month.
- The Infection Control Preventionist had begun monthly completing five real time Infection Control monitoring tools, effective October 2013.
- The Nurse Managers continued to address issues as they were identified during their real time audits.
- Unit wide or systemic issues were addressed through Unit/Infirmary meetings, specific training or a CAP. Refer to the report below regarding the development and implementation of CAPs.
- The completed tools were submitted for data entry to the Data Analyst. Completed graphs were then sent to the Compliance Nurse for processing.
- Pre-meetings with Nurse Managers were held to discuss outcomes of the audits in preparation for the monthly QA/QI meeting.

The Facility's Self-Assessment reported the monthly results for the nursing monitoring tools from June 2013 through November 2013. The chart below shows the results:

| Nursing Monitor Tools | June 2013 | July 2013 | August 2013 | September 2013 | October 2013 | November 2013 |
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| Antibiotic Therapy | 87.6% | 87.6% | 76.1% | 85.1% | 78.7% | 88.5% |
| PICA | 58% | 49.7% | 88.7% | 83.1% | 80.2% | 79.6% |
| Pre-Treatment/Post Sedation | 66.1% | 83.8% | 83.7% | 86.4% | 81.0% | 72.0% |
| Respiratory Distress/Aspiration | 67.0% | 71.0% | 66.8% | 76.0% | 73.7% | 60.7% |
| Seizure Activity | 60.7% | 68.9% | 78.1% | 74.9% | 66.8% | 71.2% |
| Status Epilepticus | 55.0% | 77.8% | 84.8% | 89.8% | 74.0% | 72.2% |
| Urinary Tract Infection | 64.1% | 74.5 | 63.8 | 73.9 | 72.8 | 68.0% |

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| | | % | % | % | % | |
| Urgent Care/ER Visits/Hospitalizations | 16.7% | 36.4 % | 37.5 % | 33.3 % | 50.% | N/A |
| Vomiting | 69.9% | 69.4 % | 72.6 % | 75.2 % | 85.2 % | 80.5% |

The Monitoring Team's independent review and discussion with the Nursing Administration Team and QA Nurse found that they acknowledged the poor results of compliance with the monitoring tools. They had evaluated the underlying factors that contributed to the poor compliance scores and taken corrective action for improvement. It was discovered that they were not using the state office's most up to date monitoring tools. The audit tools being used did not directly address individual nurse compliance. As a result, the compliance nurse and the data analyst recently began to use the most up-to-date protocol card audit tool to reflect the changes made; these new audit tools will include review of whether nurses follow the standard protocols. They were put into effect in January 2014. In addition, revisions were made to improve the quality and content of tools. Documentation requirements were included in each monitoring tool as opposed to using a standalone monitoring tool for documentation.

Inter-rater Reliability Reports for October 2013 and November 2013:
Since the last compliance review, the Nursing Department had adopted the QA Department's guidelines for conducting inter-rater-reliability checks, which required at least an 80% agreement between the nursing monitors and the QA nurses. Reportedly, when this is achieved consistently monthly, the inter-rater reliability checks will then be conducted quarterly. On 12/6/13, the Nursing Administration Team met and discussed guidelines for completing the monitoring tools. The tools were updated to reflect the instructions. The established inter-rater reliability process was also reinforced during the meeting. They determined that the overall data from the two previous months did reflect improvement. According to the QA/QI Council Report, December 26, 13, the overall percentage of agreement between the Nurse Managers audits and the QA Nurse audits showed respectively 58% and 79%. From interviews with the Nursing Administration Team and QA Nurse this process was still evolving as they continue to reconcile the interpretation of the items on the various monitoring tools.

Since the last compliance review, the Compliance Nurse continued to meet with CNE, NOO, Unit Nurse Managers, and other relevant nursing leadership/specialty nurses when indicated to review status of progress on each Section M Provision. They reviewed the results of monitoring data from the QA/QI Council Reports regarding Section M; when systemic deficiencies were identified, Corrective Action Plans (CAPs) were developed and implemented. The Nursing Compliance workgroup tracked the CAPs through to resolution, as well as evaluated and reported to the QA/QI Council the status of the effectiveness of CAPs. The Monitoring Team was only provided for review Nursing Compliance Meeting minutes for 10/29/13 and 11/15/13. Therefore, it could not be determined if there were other meetings that took place and the minutes were not made available, or whether no other meetings were conducted. However, the Nursing Compliance workgroup showed significant promise in moving Section M toward substantial compliance.

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| | | The Monitoring Team's independent review of nursing services' CAPs developed, implemented, and status of completions reported to the QA/QI Council over the past six months found:<br>• In July 2013 a CAP for Documentation was completed related to the outcome of the QA/QI data of audit tools. Out of 191 nurses, 183 (95.81%) nurses were reported trained on the CAP for Documentation. A review of the QA/QI Council Reports August 2013 through November 2013 indicated the Nursing Administration was continuing to evaluate the effectiveness of the Documentation CAP.<br>• A CAP for Urgent Care/ER Visits/Hospitalization Monitoring Tool was developed and implemented in October 2013 due to the poor results of the tool. In the Monitoring Team's independent review and discussion with the Nursing Administration Team, they explained that it was discovered that one of the reasons for the poor results on the Urgent Care/ER Visits/Hospitalization Monitoring Tool was related to the fact that some of the hospitalization information was recently being put into the Shared Drive. Therefore, some of the nurses completing the tool were not aware of the need to look for information reported in the Shared Drive. The nurse monitors were made aware of where to find all related hospitalization information.<br><br>In November 2013, the Urgent Care/ER Visits/Hospitalization Monitoring Tool was updated with interpretive guidelines for each item on the monitoring tool to ensure that all monitors were consistently interpreting the information the same way. The Monitoring Team was provided copies of five completed Urgent Care/ER Visits/Hospitalization Monitoring Tools completed in November 2013 but had not yet been reported in the QA/QI data, which showed an overall average of 88.35%. These audits were completed on the revised Urgent Care/ER Visits/Hospitalization Monitoring Tool. The revisions to the tool showed promise in reflecting improvement in quality of care and the percentage of compliance with the audits.<br><br>In November 2013, an in-service for the revised process for monitoring urgent care/ER visits/hospitalizations was developed based on the findings from the monitoring tool audits. However, training on this process did not begin until 1/2/14 due to competing demands. The projected training date for completion was 1/31/14. From a review of the training content, it appeared to address required performance measures related to all urgent care/ER visits/hospitalization nursing policies and protocols. However, due to the recent increase in hospitalizations, particularly related to bowel obstruction, a CAP was assigned to PNMT.<br>• The QA Director completed timely submission of assessment audits for ISPs. For assessments falling below the desired threshold for timeliness, the QA informed the respective disciplines that a CAP was required. The Timeliness of Assessment for ISP Audit in October 2013 found Nursing fell below the desired threshold. The RN Case Manager Supervisor initiated a CAP related to timeliness of completion of comprehensive nursing assessments that remained open at the time of the compliance review.<br>• On 12/4/13, the RN Case Manager Supervisor updated/revised the Nursing Comprehensive Assessment Monitoring Tool in response to the state's standardized Annual Comprehensive Nursing Assessment format and the Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record | |

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| | | Review/Quarterly Physical Assessment, as well as part of the CAP for Timeliness of Assessment for ISPs. The Nursing Comprehensive Assessment Monitoring Tool was too recently revised and continued to be refined so it did not yet provide reliable data. A review of the draft monitoring tool showed promise in not only improving the timeliness of completion of the nursing assessments, but also in the quality of the data monitored. The Monitoring Team will review the results of the nursing comprehensive data at the next compliance review.<br>• According to the Nursing Administrative Team, there were no other outstanding CAPs at the time of the compliance review. The improvements made to the Quality Assurance efforts showed promise for moving forward with this requirement. It is essential that the Nursing Department have a sound and reliable process for monitoring nursing practices to use in making clinical decisions.<br><br><u>Monitoring Team's Independent Assessment and Documentation of Individuals with Acute Changes in Status:</u><br>Since the last compliance review the Facility had continued to conduct to the Integrated Morning Report meetings using a formalized format. The Monitoring Team attended the Integrated Morning meeting on 1/15/14, and found the meeting format was followed. A section had been added to the format to document follow-up issues from the previous day and/or previous meetings. The Infirmary Nurse reported on the status of all individuals in the Infirmary. The Hospital Liaison Nurses provided comprehensive reports on individuals admitted to the hospitals and Long Term Acute Care Facilities. The CNE, NOO, RN Case Manager Supervisor, and Compliance Nurse also attended the meetings. The RN Case Manager Supervisor notified the RN Case Managers of any Change of Status meetings that were identified. The RN Case Manager Supervisor and/or identified Specialty Nurses were responsible for following up on any identified issues in their respective area of expertise. This information was verified by the Monitoring Team's independent review of Integrated Morning Report minutes, 1/6/14 through 1/15/14. It is essential that the Integrated Morning Reports include documentation on nursing issues that required follow-up from the meetings.<br><br>The Monitoring Team's independent interviews with the Nursing Administrative/Management team, and review of other related documents found the following:<br>• As was found in previous reviews, the Nursing Administrative/Management team had continued to put forth concerted effort to improve the quality of the content and the documentation of the Acute Care Plans by eliminating the previously used generic care plans. A new Acute Care Plan process was put in place in January 2014, to improve the individualization and quality of the content of the care plans. The process included a blank Acute Care Plan template with a bank of interventions from which the nurse could draw in developing care plans for commonly occurring acute conditions. At the time of the compliance review, 58 nurses had been trained on the new Acute Care Plan process, with a projected completion date for training by 1/31/14. In addition, all 23 Nursing Protocol Cards were implemented and all nursing staff had been trained on the protocols.<br>• All 23 Nursing Protocol Cards were fully implemented with all incumbent nurses trained on the protocols. Training on the Nursing Protocol Cards was provided in new Nurse Education Orientation and in Annual Nursing Competency training. Refer to Provision M.4 for the details of training on the | |

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| | | protocols.<br>• The Nursing Protocol Cards were incorporated into relevant Acute Care Plans for commonly occurring conditions, for which a relevant protocol was available. The protocols were implemented and followed when individuals' were placed on Nurse Watch for an acute change in status event, which may or may not require the development and implementation of a care plan.<br>• The Nursing Protocol Card Audit Tools were in the process of being updated and refined to be consistent with statewide audit tools. The refined and updated audit tool also included monitoring of documentation associated with each respective Nursing Protocol Card.<br><br>Monitoring Team independently reviewed 13 unified/active records for Individuals: #519, #326, #187, #243, #800, #286, #668, #616, #425, #28, #459, #666, and #583 selected from across Units/Infirmary, who were rated at high and/or medium risk for a variety of health conditions, during the period of October 2013 through December 2013, and found numerous examples in the records review that relevant Nursing Protocol were initiated and followed through to resolution. The following are a few examples of assessments and documentation for acute change in health status events that did not lead to an actual Change of Status:<br>• Individual #425 had a diagnosis of PICA with orders for daily PICA Risk Assessment. A review of the Integrated Progress Notes, October 2013 through 2013, found that the Nursing Protocol Card for PICA was implemented; and nursing assessments for PICA were consistently completed daily, with instructions for the Direct Support Professionals to report any evidence of PICA behavior. During the period reviewed there were no reported incidences of PICA behavior.<br>• Individual #800 had an episode of emesis on 12/15/13. Individual #800 was placed on Nurse Watch and the Nursing Protocol for Vomiting was initiated and was followed accordingly on each shift. Direct Support Professionals were provided instruction to report any vomiting to the nurses. There were no further episodes of vomiting reported. A resolution note was documented when the problem was resolved on 12/17/13. On 12/4/13, Individual #800 had an episode of head banging. The Nursing Protocol for Head Injury was initiated and followed accordingly for a mild head injury. There was documentation in the Integrated Progress Notes showed that an initial neurological assessment was completed with neurological assessments completed and documented every four hours for 24 hours, as well as documented on the Neurological Checklist until the checks were completed. The head-banging episode was resolved without complication on 12/5/13.<br>• Individual #459 had a head-banging episode on 12/26/13. The Nursing Protocol for Head Injury was initiated and followed accordingly for mild head injury. There was documentation in the Integrated Progress Notes that showed an initial neurological assessment completed with neurological assessments completed and documented every four hours for 24 hours, as well as documented on the Neurological Checklist until the checks were completed. The head-banging episode was resolved without complication on 12/27/13. On 12/1/13, Individual #459 had an episode of constipation. The Nursing Protocol for Constipation was initiated and followed accordingly. The primary care provider was promptly notified and a Bisacodyl rectal suppository was ordered and administered. The suppository was effective and without further complication. | |

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| | | • Individual #616: On 11/2/13, Individual #616 complained of pain in the left knee secondary to an abraded area. Individual #616 was placed on Nurse Watch for 24 hours and the Nursing Protocol for Pain was initiated. Tylenol 650 mg was administered at 0043 for pain. Direct Support Professionals were instructed to report any signs of pain or discomfort in the left knee. At 1149, the nurse documented that the Tylenol was effective in relieving pain in the left knee. There was a resolution note indicating the pain in the left knee was resolved.<br><br><u>Areas that need continued improvement:</u><br>• Documentation errors were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed.<br>• Late entries were not consistently documented correctly.<br>• The time and/or dates of entries into the Integrated Progress Notes were not consistently included.<br>• 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.<br>• The method temperatures were taken was not consistently documented. Due to the variation in degrees of temperatures taken by different methods, the method the temperatures were taken must be considered in order to accurately interpret the measurements. Oxygen saturations did not consistently indicate whether they were measured on room air or oxygen.<br>• The legibility of the nurses' handwriting had somewhat improved but the signatures and titles for some nurses continued to be illegible.<br><br><u>Hospital Liaison Nurses' Activities:</u><br>The Monitoring Team independently validated the activities below through interviews with Hospital Liaison Nurses, attendance at the Integrated Morning Report (IMR) Meeting on 1/15/14, review Integrated Morning Report Meeting minutes 1/6/14 through 1/15/14 and review of daily Hospital Liaison Reports for recent and/or currently hospitalized Individuals: #423, #590, #606, #105, #279, and #336. The Hospital Liaison Nurses continued to perform the positive practices found in previous compliance reviews. These activities included the following:<br>• In addition to their attendance at the daily IMR, they also attend the Incident Management Review Team meetings twice a week to report on individuals admitted to the hospital and Long Term Acute Care (LTAC) facility.<br>• Continued to attend post-hospital discharge IDT meetings and report on individuals' hospital course, status at discharge and need for additional supports and services.<br>• Continued to strengthen relationships with the local hospital and LTAC facility; as a result they reported improvements in the care as well as continuity of care with improved outcomes. As was found in the previous compliance reports, the Hospital Liaison Nurses, Skin Integrity, and Infection Control Preventionist working with the LTAC facility had pointed out the need for hiring more critical care nurses and therapists to improve the outcomes of the more medically fragile and complex individuals admitted from DSSLC. As a result, Nursing Administration reported the LTAC facility had been hiring | |

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| | | and recruiting more critical care nurses and therapists to improve the quality of care to DSSLC's more medically fragile and complex individuals admitted to their facility.<br>• Continued to enhance and work collaboratively with the hospital's respiratory, physical, and occupational and speech therapists, dietary, emergency, and gastrointestinal departments, as well as with the hospitalist, pulmonologist, and infection control specialists.<br>• Established relationships with hospital's information management to obtain copies of Emergency Medical System Reports regarding care individuals received while in route to the hospital, when needed to provide more information and clarification of records.<br>• Attended the death reviews to provide additional information and to answer any questions the death review committee might have regarding individuals' hospital stay. They reported this had helped to expedite and improve the death review process.<br>• Continued to make daily hospital rounds (Monday through Friday) to individuals hospitalized. Since the last compliance review, Nursing Administration reported they had made arrangements with the hospitals for the Hospital Liaison Nurses to have access to the hospital records from their homes to check on hospitalized individuals on the weekends or anytime there was a long break over three days to address any need that required attention, as well as to update the primary care providers and other IDT members when indicated. It was explained that one of the Hospital Liaison Nurses can stay connected to on line reports through Go To My PC and is available via cell phone over the weekends or anytime there was a long break over three days. If Hospital Liaison is unavailable communication occurs through Infirmary Charge Nurse. Having one of the Hospital Liaison Nurses on call provided better continuity of care since they were more familiar with hospitalized individuals' health status, as opposed to assigning the calls to a campus nurse who may not be as familiar with individuals' health status as the Hospital Liaison Nurses who had been in contact with the individuals and their respective hospital personnel.<br>• They continued to communicate/collaborate with the DSSLC Infection Control Preventionist and PNMT Nurse when hospitalized individuals were diagnosed with aspiration pneumonias and other pneumonias to ensure these nurses were provided with accurate documentation. They also communicated/collaborated with the Skin Integrity Nurse when skin integrity issues were identified. If there were issues regarding individuals' immunizations the Infection Control Preventionist was notified. If individuals experienced adverse drug reactions they were reported to the Pharmacist and respective primary care providers.<br>• They meet with the Nursing Compliance Team to review and discuss the Urgent Care/ER Visits/Hospitalization Monitoring Tool findings in an effort to identify issues with the tool and/or care performance issues in an effort to take corrective actions to improve the accuracy and quality of the care reflected in the data. For example, they identified and discussed the issue of the hospital related information/records not being placed in the active records timely by the record clerks. This lack of hospitalization paperwork not being in the chart at the time the tool was completed led to poor results. As a result, the policy was changed to place the hospital information/records into individuals' Share Drive/AVATAR and the original hard copies were sent to medical records and placed in their permanent files. In addition, the Hospital Liaison Nurses' assessments and findings were reported on the Hospital | |

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| | | Liaison Report Forms, and then reports were scanned into individuals' virtual folders to be available to relevant IDT members.<br>• On November 1, 2013, they begin the process on entering hospital transfers and other related information into the AVATAR system. This process was in the beginning stages but it was expected to provide more accurate information about transfers between different facilities, as well as to the Infirmary on campus.<br><br><u>Monitoring Team's Independent Review of Currently Hospitalized Individuals:</u><br>In order for the Monitoring Team to independently review hospital related records, a document request for offsite review was made for a sample of individuals hospitalized within the past week and/or who were currently hospitalized. The document request included related Integrated Progress Notes, accompanying physician orders, and any other associated required Hospitalization/ER/Transfer documentation for Individuals: #590, #606, #105, and #336. However, the only documentation received for the individuals' were the Hospital Liaison Reports and information from the hospital course. The documentation provided for review showed that the four of four (100%) of the requirements were met for the Hospital Liaison Nurses' responsibilities according to the Nursing Services and Hospitalization/Discharge/Transfer Policies. Because the hospitalization information requested was not provided as requested, the other nursing compliance requirements according to these policies and the Nursing Protocol Card for Emergency/Hospital Transfer could not be determined. It was regrettable that after the investment of effort put forth, as reported above, to improve the quality of care for hospitalized individuals that the requested documentation was not provided for review. At the next compliance review the Monitoring Team will review for compliance with the Nursing Services Policy, Hospitalization/Discharge/Transfer Policy, and the Nursing Protocol Card for Emergency/Hospital Transfers, with the expectation that all required documentation will be provided leading up to the reason for hospitalization, during hospitalization, and upon discharge.<br><br><u>Diabetic Nurse Educator Activities:</u><br>Since the last compliance review, the Diabetic Nurse Educator had continued maintain the positive practices previously identified and had continued to make progress toward the management of individuals diagnosed with diabetes. The Monitoring Team's interview with the Diabetic Nurse Educator and review or activities reported included:<br>• Attended endocrinology appointments with individuals and staff. Provided the endocrinologist with pertinent information and requested reports. Upon return from appointments provided the individuals' primary care with any updates or recommended changes in diabetic management/treatment.<br>• Monitored and trended blood sugar levels for individuals with insulin dependent diabetes. Worked closely with the primary care providers and endocrinologists to manage diabetic medications more effectively, for both oral and injectable medications. As a result, some individuals have lessened the amount of their diabetic medications required. For other individuals (for example, Individual #35) better management of diabetic medications have lessened the incidence of hypoglycemia.<br>• Worked with a team of certified dietitians, RN Case Managers, psychology, nurses, and family, as well as | |

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| | | primary care providers to develop plans for Individual #668 with brittle diabetes while incorporating as much as possible of his past regimen.<br>• Worked with specialty nurses including the Skin Integrity Nurse to resolve skin integrity issues with any of the individuals followed, for example, Individual #517.<br>• Pre-diabetic activities included: Quarterly labs were in place to identify any new onset problems. If individuals develop trends, the respective primary care providers, RN Case Managers and nurses or any other concerned staff can make a referral to the Diabetic Nurse Educator for consultation, who will follow-up and give the primary care providers recommendations for follow-up. If the primary care provider agreed with the recommendation they were followed. Through such monitoring some individuals have lessened the frequency for fasting blood sugar testing and some were ultimately discontinued, for example Individual #50. In addition, the Diabetic Nurse Educator followed individuals' diagnoses of metabolic syndrome and individuals prescribed with medication that may cause blood sugar elevations.<br>• Maintained kits for oral intake in the units with individuals diagnosed with diabetes for diabetic emergencies.<br>• Continued the Diabetic Group Training/Education Meetings on an as needed basis. The purpose of the training/meeting was to educate the individuals on campus as to good food choices. The training/meetings also included primary care providers, nurses, dietitians and direct care professionals. The next meeting was scheduled for March 2014. The Facility was looking forward to setting a time and ideas for a Diabetic Day Food Fair.<br>• Worked to lessen the amount of time spent in the office and on the computer to better utilize time spent in the homes and on diabetic education. In the future the Diabetic Educator would like to spend more time in the homes observing and educating the specific needs of those individuals diagnosed with diabetes.<br>• Reported diabetic related activities at the quarterly PNMC meetings and Pharmacy and Therapeutics Committee meetings, with supporting documentation included were in the minutes.<br><br>If this were a standalone requirement, this Provision would be considered in substantial compliance.<br><br><u>Skin Integrity Nurse Activities:</u><br>The Monitoring Team's independent interview and review of documents found that the certified Skin Integrity Nurse, who was hired at the time of the last compliance review, had made significant progress in improving the organization and management of skin integrity/decubitus ulcer care, as well as tracking, analyzing, and trending skin integrity/decubitus data, and then developing and implementing corrective actions plans, when indicated to improve the quality and management of skin integrity/decubitus ulcer care. The following summary describes the activities implemented and conducted over the past six months.<br><br><u>Changes Made in Tracking and Reporting Skin Integrity Issues/Decubitus Ulcer Data:</u> The format for the Skin Integrity Report was changed. The monthly reports now contained decubitus graphs that showed at a glance the number and stages of decubitus ulcers, where they were acquired, i.e., hospital, Infirmary and/or | |

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| | | apartments, and the incidence rate. Additionally, the monthly reports contained an accompanying narrative documentation detailed the status of each individual's skin integrity issues/pressure ulcers that included: History, action taken, status of wound healing and if resolved the resolution dates for all currently active wounds, as well as newly diagnosed skin integrity issues/decubitus ulcers for the month. Non-pressure related skin integrity issues for the month were also included in the reports. The reports were presented at the monthly PNMC meetings and attached to the minutes. The reports were also saved in the nursing shared drive to make them available to the nurses caring for individuals that have active skin integrity issues/decubitus ulcers.<br><br>Skin Integrity Activities Implemented to Reduce/Prevent the Incidence of Skin Integrity Issues/Pressure Ulcers: The Skin Integrity Nurse reported that most of the Facility's decubitus ulcers were acquired at the hospitals and/or Long Term Acute Care (LTAC) facilities. In an effort to reduce/prevent the incidences of skin integrity/pressure ulcers the Skin Integrity Nurse performed the following activities:<br>• Received reports from the Hospital Liaison Nurses when individuals' first signs of possible skin integrity issues arise.<br>• Attended the Integrated Morning Report every morning where the Hospital Liaison Nurses reported on any identified skin integrity issues.<br>• Followed-up on individuals in the hospital/LTAC with visits/telephone contacts to assess the skin integrity issues and collaborated with the wound care nurse to start treatment before returning home.<br>• When individuals with histories or current decubitus ulcers were to be admitted to the hospital/LTAC, contacted the respective wound care nurse and gave a report on their current skin integrity status, treatments, and risks.<br>• Received referrals from the triage nurse and PNMT RN on individuals in response to post hospital/LTAC discharge assessments.<br>• Attended IDT meetings for individuals with a history of or who had current skin integrity issues, as well as IDT post-hospital discharge meetings.<br>• Any decubitus ulcers that were identified as Stage III or greater were referred to the PNMT. Frequently the Skin Integrity Nurse completed skin assessments on individuals alongside with the PNMT RN.<br>• After the Skin Integrity Nurse completed individuals' wound assessments, their status were reported to the respective primary nurses, charge nurses, RN Case Managers, and primary care providers. The Skin Integrity Nurse worked collaboratively with the physical and occupational therapists regarding the need for positioning adjustments or other assessments, as well as when wounds were healed to assess for preventative measures.<br>• The Skin Integrity Nurse attended all individuals' appointments with the Wound Care Specialist to prevent the loss of important information in translation. Speaking directly with the Wound Care Specialist allowed for an understanding of the purpose and goals of the recommended treatments. Attendance at the appointments also enhanced the knowledge of wound care that could be applied to future healing and prevention for other individuals.<br><br>In addition to the above activities, the Skin Integrity Nurse identified areas that needed continued | |

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| | | improvement, which included: Development and implementation of a protocol card for skin integrity issues, a better method of getting access to consults by moving her office close to the fax machine, updating the ACP template, and creating a wound care team that included all relevant disciplines.<br><br><u>Skin Integrity/Decubitus Ulcer Training Activities:</u><br>• In December 2013, the Skin Integrity Nurse developed and implemented Preventing Skin Breakdown in-service training to refresh and help the direct care professions understand the causes of skin breakdown and decubitus ulcers with a focus on hygiene, positioning and when to notify the nurse of possible skin problems. The training was provided to all Unit Directors, Nurse Managers, and RN Case Managers. Training materials and signed training rosters were provided that validated the training. The future plan was to provide this in-service training to the direct care professionals on apartments with individuals who have medium to high risk ratings for impaired skin integrity. The units with few at risk individuals will be in-serviced on as needed basis. The in-service training was planned for Houston Park and Cedar Falls on their "lap over day" on the last Friday in January 2014. The Preventing Skin Breakdown in-service training material was placed in the nursing file to be available when a specific individual need arises. In addition, in-service training was provided to unit/home staff for specific individuals who have complicated cases of skin integrity issues. For example, specific in-service training was provided to all of Individuals #776 and187s' staff regarding care and management of J-tube soma sites. Signed in-service training records were provided that validated this training.<br>• The Skin Integrity Nurse taught Basic Wound Care Classes at New Nurse Orientation, which included documentation, necessary supplies, when, and what skin integrity issues to refer the primary care provider and Skin Integrity Nurse, i.e., any suspected signs of skin integrity pressure.<br>• In November 2013, the Skin Integrity Nurse attended the Nurse Educators' Conference in Austin to teach basic wound care and documentation to the DADS' nurse educators.<br><br><u>Annual Pressure Wound Data:</u><br>The chart below shows the monthly pressure wound data reported from January 2013 through December 2013: | |

| Pressure Ulcers | 1/13 | 2/13 | 3/13 | 4/13 | 5/13 | 6/13 | 7/13 | 8/13 | 9/13 | 10/13 | 11/13 | 12/13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Individuals | 2 | 2 | 3 | 5 | 4 | 5 | 7 | 6 | 5 | 3 | 3 | 3 |
| Apartment Acquired | 2 | 1 | 0 | 3 | 2 | 1 | 8 | 3 | 1 | 1 | 1 | 0 |
| Infirmary Acquired | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Hospital Acquired | 0 | 1 | 5 | 5 | 2 | 9 | 3 | 11 | 8 | 2 | 2 | 4 |
| Stage I | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Stage II | 2 | 0 | 0 | 1 | 3 | 4 | 3 | 8 | 3 | 1 | 1 | 0 |
| Stage III | 0 | 0 | 4 | 4 | 0 | 3 | 0 | 3 | 2 | 0 | 0 | 1 |
| Stage IV | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unstageabl | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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| Deep Tissue Injury | 0 | 0 | 2 | 1 | 0 | 3 | 8 | 3 | 4 | 2 | 2 | 3 |
| Total Wounds | 2 | 2 | 6 | 8 | 4 | 10 | 12 | 14 | 9 | 3 | 3 | 4 |

The above data showed a progressive reduction in the incidences of pressure wounds from a peak of 14 in August 2013 down to four in December 2013. The stages of the pressure wounds were all also reducing. The majority of the pressure wounds were hospital acquired. It appeared that the activities/interventions reported above were beginning to be effective in the reduction of pressure wounds, as well as their stages/depth of involvement. The Monitoring Team will continue to review the status of pressure ulcers at the next compliance review.

Monitoring Team's Independent Review of Individuals with Recent and/or Active Pressure Wounds:
At the time of the compliance review, the Skin Integrity Nurse stated that in December 2013 there were four individuals diagnosed and treated for pressure related wounds, of which all were hospital acquired. The Monitoring Team independently reviewed five individuals' records with recent and/or active pressure wounds. Individuals included: #423, #187, #286, #86, and #129. Individual #286's deep tissue injury was now healed. Individual #423 was in the hospital. The Monitoring Team accompanied by the Skin Integrity Nurse, NOO and respective Unit Nurse Manager visited/observed Individuals #187, #129 and #86, who remained at the Facility. Findings included:

- Individual #187 was observed in the Infirmary. Individual #187 was recently discharged from a LTAC facility where a deep tissue injury to the right heel was acquired. The Skin Integrity Nurse was observed changing the dressing, assessing the wound, and applying treatment. The wound on the right heel was assessed and determined resolved. Individual #187 was to continue to wear the foot pillows bilateral to prevent pressure on the heels. The Skin Integrity Nurse also assessed, treated, and dressed the J-tube stoma site that was excoriated secondary to leaking gastric juices. The stoma appeared red at the immediate site, with pink peri wound skin, with yellow drainage and was tender to touch. There was no order or signs of infection. The excoriation of the stoma site was a chronic condition. The Skin Integrity Nurse stated much effort had been made to stop the leaking of the J-tube by changing tubes but to no avail. The treatment strategy was to pack the site with Kalostat ribbon to prevent the gastric juice from leaking onto the surround tissue. In addition, a special compounded paste of Maalox, Zinc Oxide, miconazole and polysporin powder was applied to surrounding tissue to act as a barrier to prevent tissue damage and infection. Privacy curtains were used during the dressing change. The Skin Integrity Nurse informed the primary care provider of the status of the wounds. New orders were received to apply Aquaphor Healing Ointment daily to the right heel for two weeks to promote tissue maturation. No new orders were received for the stoma site. The primary care nurse and direct care professionals were provided the results of the wound assessments and further instructions for care of the wounds.
- Individual #129 was observed in the Infirmary. Individual #129 was recently discharged from the hospital where a Stage II pressure wound to the left foot was acquired. The Skin Integrity Nurse was

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| | | observed changing the dressing, assessing the wound, and applying treatment. The wound on the left foot showed evidence of continued improvement but was still classified as a Stage II pressure wound. Individual #129 was to continue wearing the pressure relieving boot on the left foot to promote healing and a foot pillow on right foot to prevent pressure and skin breakdown. Privacy curtains were used during the dressing change. The Skin Integrity Nurse notified the primary care provider of the assessment findings. No new orders were given. The primary care nurse and direct care professionals were provided the results of the wound assessment and instructions for wound care.<br><br>While observing wound care, Individual #129 was observed to have a pronounced malodorous body smell of an infectious like nature. The Monitoring Team asked the accompanying Nurse Manager and primary care nurse if they had noticed the odor and its origin. Both denied noticing the body odor. It was puzzling how this pungent body odor could have been overlooked, particularly in the Infirmary where there was enhanced care provided. The Nurse Manager said they would follow-up to determine the origin of the body order. The Monitoring Team asked the Infection Control Preventionist to also assess Individual #129 to determine the origin of the body odor. Later the Infection Control Preventionist provided Monitoring Team the assessment findings. The Infirmary Nurse informed the Infection Control Preventionist that the smell was coming from Individual #129's vaginal area. After cleaning the area the smell went away. There was no abnormal vaginal discharge observed. It was explained that Individual #129 liked to cross her legs a lot not leaving enough air to circulate to her vaginal area. The Infirmary Nurse was to remind the staff to keep the area clean and dry. They did a urine culture, for which the preliminary results came back with no growth. The Infection Control Preventionist reminded the Infirmary Nurse to have the primary care provider discontinue the Levaquin if the final results come back with no growth. It is important to note that Individual #129 was recently discharged from the hospital after being treated for pneumonia with sputum positive for pseudomonas. No doubt she was treated with antibiotics. Antibiotics have the potential to cause vaginal Candidiasis (yeast) infections. Based on history and current antibiotic use, it would have seemed prudent to perform a wet mount prep of vaginal secretions to rule out or rule in a vaginal yeast infection, as well as any other potential vaginal infections.<br>• Individual #86 was in observed in Houston Park. Individual #86 was recently discharged from a LTAC facility where a Stage II pressure wound to the right great toe lateral/distal area was acquired. The Skin Integrity Nurse was observed changing the dressing, assessing the wound, and applying treatment. The right great toe remained purple with dried blood at the nail bed. The wound was mostly intact without drainages or signs of infection. The current treatment was continued. A privacy blind was used during the dressing change. The primary care nurse and direct care professionals were provided the results of the wound assessment and instructions for wound care.<br><br>After the observations were made, the Monitoring Team discussed the procedure for removing and disposing of contaminated dressings with the Skin Integrity Nurse and Infection Control Preventionist. The Skin Integrity Nurse used personal bandage scissors to remove dressings, when the contaminated dressing were removed they were folded outside-in and laid on convenient surfaces without a protective barrier underneath, and then the contaminated dressing were disposed of in the individuals' room garbage cans. | |

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| | | There was a lengthy discussion regarding nurses using their personal bandage scissors for dressing changes. The Infection Control Preventionist will evaluate the practices of using the nurses personal bandage scissors to change dressing and the disposal of contaminated dressings. This issue will be followed up at the next compliance review.<br><br>If this requirement were a standalone Provision, it would be considered close to achieving substantial compliance. Refer to Provision M.3 for reports on Skin Integrity Acute Care Plans (ACPs), Integrated Health Care Plans (IHCPs) and accompanying documentation.<br><br><u>Infection Control Preventionist Activities:</u><br>The Infection Preventionist 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:<br><br><u>New and/or Revised Infection Control Policies, Procedures, Protocols, Processes and/or other documents addressing Infection Control:</u><br>• DSSLC Nursing Guidelines: Infection Control Processes: Real Time Infection Control Note/Real Time Audit, 8/1/13<br>• DSSLC Nursing: Hand Hygiene Policy, Revised: 10/22/13<br>• DSSLC Nursing: Infection Prevention and Control Policy, Revised: 10/22/13<br>• DSSLC Nursing: Protocol for Suspected or Confirmed Bed Bug Infestation, 12/13/13<br>• DSSLC Nursing: MDRO Policy, Revised: 10/22/13<br>• DSSLC Nursing: Influenza Vaccine Administration Protocol for DSSLC Residents, Revised: 11/6/13<br>• DSSLC Nursing Guidelines: Steps to take when a unit/apartment has a suspected/confirmed case of Influenza (outbreak), 10/24/13<br>• DSSLC Nursing: Employee Call-in Log for Flu Symptoms or Diagnosis of Flu<br>• DSSLC Nursing: Construction Renovation, and Maintenance Program, 12/12/13. The purpose of this program is to minimize the risk of acquisition of healthcare associated infections (HAIs) to individuals that may result when fungi or bacteria are dispersed into the air via dust or water aerosolization during construction, renovation, or maintenance activities in or near the Facility.<br><br><u>Infection Control Training Activities by the Infection Control Preventionist:</u><br>• 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. The Competency Development and Training (CDT) Due/Delinquent List, printed 12/9/13, for Infection Control annual refresher training, showed that 19 employees were due/delinquent on this training. Ten of these 19 (53%) employees worked on the night shift. The Infection Control Preventionist and the employees' respective supervisors should ensure their training is brought up to date. It is essential that all employees remain current in their annual refresher | |

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| | | Infection Control Training to prevent the spread of infections.<br>• According to the Self-Assessment, when changes in Infection Control Policies, Procedures, Processes, Protocols, and Guidelines occurred relevant staff were trained.<br><br>Physical Nutritional Management Committee (PNMC) Meetings: The Infection Control Preventionist continued to present infection control data on a quarterly basis and as needed, at the PNMC meetings for further review and disposition. The Infection Control Preventionist also presented new cases of aspiration pneumonia weekly. The aspiration pneumonia information presented was based on individuals' active record reviews as well as from the Infection Control Preventionist's visits to individuals who were hospitalized and review of their hospital records. In addition, the Infection Control Preventionist reported on the following infection control monitoring activities:<br><br>Infection Control Monitoring Activities: The Infection Control Preventionist/Designee continued to complete monitoring monthly on the following tools: AVATAR Pneumonia/Aspiration Pneumonia Tracking; AVATAR Immunization Tracking; AVATAR Infection Tracking; Communicable Disease Database; Individual Immunization Database; Employee Immunization Database; Handwashing Skill Assessment Tool; Home/Apartment Surveillance Report; Antibiograms; and Hygiena ATP Monitoring Tool.<br><br>The above monitoring data were tracked, analyzed, trended, with corrective actions taken on identified deficiencies as needed. This information was presented to the PNMC for further review and disposition quarterly and/or more often when indicated. This information was validated through the Monitoring Team's independent interview with the Infection Control Preventionist, review of supporting documentation provided in the document request, review of PNMC Meeting Minutes and accompanying handouts from June 2013 through January 9, 2014, and attendance at the PNMC Meeting on 1/16/14.<br><br>The Monitoring Team's independent review of infection control data presented at the PNMC Meeting on 1/16/14, for January 2013 through December 2013, showed that that the Infection Control Preventionist continued to maintain a comprehensive and detailed system for tracking, analyzing, and trending all aspects of infection control related data. There was further documentation that validated clinically sound and appropriate corrective actions were taken with follow-up for effectiveness for respective infection control data found to require such action to prevent and/or control the spread of infections. A summary of findings are reported below:<br>• The Influenza Activity Report 2013-2014 for Residents/Employees showed:<br>o A total of 16 individuals were confirmed with a case of influenza (11 individuals diagnosed with Influenza A and 5 individuals with Influenza B). A total of 144 individuals were administered Tamiflu. There were no new cases of influenza reported for January 2013.<br>o At total of six employees were confirmed with a case of influenza. A total of eight employees called in sick and/or were sent home with influenza-like symptoms.<br>There was documentation that clinically sound and appropriate guidelines for steps to take when a center has a confirmed/suspected case of influenza were implemented to manage and control the outbreak of influenza. | |

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| | | • Real Time Audits for Acute Infections, October 2013 through December 2013, showed five records were audited monthly on acute care plans for acute infections by the Infection Control Preventionist to ensure that acute care plans were initiated and implemented, medical providers and Infection Control Preventionist were notified timely, individuals with acute infections were treated with appropriate antibiotics, proper standard precautions were put in place, and staff were educated/trained on the modes of transmission, and signs/symptoms to report to nursing. The chart below shows the Real Time Acute Infection Audit results: | |

| Items Monitored | October 2013 | November 2013 | December 2013 |
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| Has there been a care plan implemented for actual or potential infectious Illnesses? | 80% | 60% | 100% |
| Is the care plan clinically sound? | 80% | 60% | 100% |
| When a care plan is implemented there is documentation that the nursing staff have appropriately personalized the care plan specifically for the individual? | 80% | 60% | 100% |
| If applicable, the individual was treated with antibiotic in alignment with culture and sensitivity results of lab. | 100% | 100% | 100% |
| Appropriate interventions to limit the spread of infection have been implemented as follows: Timely reporting to physician and Infection Control Preventionist is documented. | 100% | 100% | 100% |
| Proper standard and/or isolation precaution was followed. | 100% | 100% | 100% |
| Education/training for staff and individual (related to prevention mode of transmission of illness) was conducted. | 80% | 60% | 100% |
| Sufficient and appropriate supplies necessary for adherence to standard precautions were available and/or were ordered. | 100% | 100% | 100% |
| Observation of staff's adherence to proper standard and/or isolation precautions. | 100% | 100% | 100% |

For items on the Real Time Acute Infection Audits that fell below 100% compliance, there was

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| | | documentation that clinically sound and appropriate corrective actions were taken with the respective RN Case Managers.<br>• Adenosine Triphosphate (ATP) Swab Tracking Reports for 11/22/13 and 1/13/14. On 1/13/14, ATP Swab Testing analysis/interpretation of data showed the Infection Preventionist tested four different surface locations on 512A, 512B, 512C, and 521D as a follow-up to the ATP Swabs done on 11/24/13. The results of the swabs on all of the different apartments showed an increase in surface contaminations compared to the 11/22/13 results. All four apartments failed the majority of the swabs done on the target locations that included bathing tables, tube feeding pumps, doorknobs, and mechanical lift control handles. Appropriate corrective action was taken to correct/prevent surface contamination with responsible staff. This report was provided to all relevant members of the interdisciplinary team.<br>• The Monthly Handwashing Compliance Report, January through December 2013, showed an overall compliance rate of 96-100%. The monthly narrative information showed that on the spot corrective action was implemented if staff observed failed to follow any of the required handwashing requirements.<br>• The Summary of Infection Incidences for the Months of October, November, and December 2013 (Fourth Quarter) reported the following findings:<br>o <u>Upper Respiratory Infections:</u> There was a slight increase in the incidents of respiratory infection during the fourth quarter, with 47 cases reported. The majority of the infections were treated on campus with antibiotics for bronchitis, sinusitis, and rhinitis. A few individuals were treated for allergic rhinitis that was not included in the overall report. Westridge 522 had the highest incidence of respiratory infections. The infection incidence rate went up from 1.27% in the third quarter to 3.18% in the fourth quarter. There was documentation that clinically sound and appropriate corrective action measures were put in place to control and prevent the spread of respiratory infectious illness.<br>o <u>Conjunctivitis:</u> The incident rate of conjunctivitis had trended down significantly since February 2013. There were 18 cases diagnosed and treated in the fourth quarter. During the fourth quarter the incident rate was 1.22%. The majority of the conjunctivitis cases were bacterial; all were treated on campus with antibiotic eye drips. There were a few individuals' that were treated on campus for allergic conjunctivitis that were not added to the report. There was documentation that clinically sound and appropriate corrective actions remained in place to control and prevent cross contamination and prevent the spread of conjunctivitis infections.<br>o <u>Pseudomonas</u>: The pseudomonas incidence rate for the fourth quarter slightly increased by 0.21% compared to the third quarter report. There were 10 individuals diagnosed and treated in the fourth quarter. They were all treated at the hospital. Pseudomonas Aeruginosa was cultured in the sputum of seven individuals, in the urine of two individuals, and in one individual's blood. They were all community-acquired infections. The majority of the individuals treated were from Cedar Falls. There was documentation that clinically sound and appropriate corrective action measures were in place to control and prevent the spread of infections. | |

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| | | o Urinary Tract Infection (UTI): The incidence of UTI infection rate was trending down in the fourth quarter. It went down by 0.36% compared to the third quarter report. There were 16 individuals diagnosed and treated at the hospital and 17 individuals were diagnosed and treated on campus. Cedar Falls had the highest incidences of infections. There was documentation that clinically sound and appropriate corrective action measures were in place to control and prevent of UTI infections.<br>o Skin and Soft Tissue Infections (SSI): The incidences of SSI continued to trend down to 3.65%. There were a total of 54 SSI cases diagnosed and treated with antibiotics in the fourth quarter. SSI cases included cellulitis, folliculitis, furuncle, paronychia, stoma infections, and human bites. In the months of May and June the Infection Control Preventionist started tracking fungal/yeast skin infections. These numbers were not reflected on the quarterly report but were reported separately during the monthly report to the PNMC. There was documentation that corrective action measures were in place to control and prevent SSI infections.<br>o Clostridium Difficile (C-diff): The C-diff infection incidence rate in the fourth quarter continued to show a low trend of .0.34%. Three individuals developed the infection while they were in the hospital. Two individuals were diagnosed and treated on campus. The majority of the individuals were from Cedar Falls. On 7/11/13, the C-diff Management Protocol was presented to and approved by the PNMC. There was documentation that showed the protocol was put in place to manage cases of C-diff.<br>o Vancomycin Resistant Enterococcus (VRE): The incidence VRE infection rate in the fourth quarter continued to show a low trend at 0.14%. Two cases of VRE were diagnosed and treated. There was documentation that showed the protocol was put in place to manage cases of VRE.<br>o Methicillin Resistant Staphylococcus Aureus (MRSA): The incidence of MRSA infection rate trended down to 0.06% during the fourth quarter compared to the third quarter report. The majority of the cases were diagnosed and treated in the hospital. They were all community-acquired infections. The sites where MRSA was found were in the noses of eight individuals, in the sputum of one individual, and in a wound of one individual. There was documentation that showed the protocol was put in place to manage cases of MRSA.<br><br>After the Monitoring Team's independent review of the infections reported, it was noted that the highest incidences of infections were occurring in Cedar Falls. This unit supports medically complex individuals who are also likely to be immunosuppressed. The corrective action measures put in place for managing the various types of infections appeared clinically sound and appropriate. However, due to the high incidence rate of infections in Cedar Falls, the Infection Control Preventionist in collaboration with the PNMC should consider looking collectively at all types of infections to explore any underlying factors that might be contributing to the high infection rates that might have been overlooked; and where additional infection control/prevention measures may be indicated.<br>• In addition, the Infection Control Preventionist presented new cases of aspiration pneumonia at the daily Integrated Morning Report, weekly at the Incidents Management Review Team, and presented a monthly report on clinical indicators for all infections at the QA/QI Council meetings. For infection data | |

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| | | and disposition regarding aspiration pneumonia and pneumonias reported to the QA/QI Council, refer to Section O and Section L of the report.<br><br><u>Monitoring Team's Independent Review of Other Infection Control Activities and Data:</u><br>• There were no reports of infectious trends for employees beyond the influenza outbreak described above.<br>• The Facility continued to contract with an Infectious Disease Doctor who provides consultation services on individuals' infections and education to clinical staff, when indicated.<br>• The Infection Control Preventionist Nurse continued to prepare monthly antibiogram/epidemiology reports that provided data to the primary care providers on appropriate usage of antimicrobial agents. The data were provided to the medical providers and reported at the PNMC meetings. For example, the interpretation of the Antibiograms, November 2013 through December 2013, showed the medical providers used the appropriate antibiotic depending on the sensitivity of organisms isolated:<br>o The majority of urine cultures done in the fourth quarter were positive for Escherichia coli (E-coli) and Klebsiella Pneumonia.<br>o Individuals' with E-coli in their urine were treated with Keflex, Augmentin and Nitrofurantoin, which were all sensitive to the microorganisms.<br>o Medical providers were not prescribing Cipro for E-coli due to its high resistance to the organism.<br>o Individuals who were positive for Klebsiella Pneumonia were treated with Nitrofurantoin-Mono, which was 100% sensitive to the organism.<br>• In November 2013, the Facility began using the AVATAR Immunization Tracking system for entering all immunizations on new individuals admitted to the Facility. However, The Infection Control Preventionist identified time issues for immunization data entry into the AVATAR system. Time issues were also identified with entering infection data into the AVATAR system. Recently additional staff resources were added to assist with data entry.<br>• For 2013-2014, 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.<br>• 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.<br>• For 2013-2014 flu season, there was a 99% compliance rate for individuals receiving influenza vaccinations. One individual was reported to have declined the flu vaccination and another individual did not receive the flu vaccination due to allergy to the vaccine. Preventative measures were put in place for the two individuals who did not receive the flu vaccination. The Infection Control Preventionist provided training to the staff and individuals to:<br>o Encourage individuals to frequently wash their hand and if they refused to offer another alternative like to use of antiseptic hand gels.<br>o Remind individuals about practicing respiratory etiquette like covering their nose/mouth with the crook of their elbows or with a tissue paper.<br>o Use proper disposal of used paper towels. | |

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| | | o During a flu outbreak staff were to make sure these individuals did not go into apartments that have confirmed flu cases.<br>o Clean and disinfect environmental surfaces or highly touched areas with disinfectant wipes (Saniwipes).<br>• For 2013-2014 flu season, there was a 34% compliance rate for employees receiving influenza vaccinations. These vaccinations were made available to employees though the Flu Vaccination Clinic through January 2014. Employees who refused the vaccines were required to complete the Influenza Declination Form. As of 11/22/13, 100 Influenza Declination Forms were turned in, of which 48 declined due to receiving the flu vaccine elsewhere and 52 declined due to personal reasons. Employees were provided education/in-service on the importance of getting flu vaccinations especially since they are working with the majority of individuals' who are immunocompromised and an older population.<br>• Currently 55.3% of the employees were vaccinated with Hepatitis B. Although this is not a required vaccination for employment at the Facility, the Infection Control Preventionist and Clinic Nurse continued to offer the Hepatitis B vaccinations during New Employee Orientation. Employees were also given the Hepatitis B Declination Form and were asked to explain the reason they choose to decline the vaccines. The Infection Control Preventionist explained the importance of getting the Hepatitis vaccine during New Employee Orientation. In addition, new employees were taught what to do during a blood borne pathogen exposure, stressing the importance of hand washing, standard precautions, environmental cleaning/disinfection, proper disposal of waste products with potential infectious material, and care of sharps.<br>• It was positive to find, as recommended in previous reviews, that the Infection Control Preventionist had developed and implemented formalized guidelines for Infection Control Processes for Real Time Infection Control Notes and Real time Audits. These guidelines will enable continuous surveillance, real time alerts/reporting, and timely analysis of infections. Refer to Provision M.3 of the report regarding compliance with these guidelines, Acute Care Plans, and management of infections.<br><br>It was readily apparent to the Monitoring Team through interviews with the Infection Control Preventionist, review of supporting documentation provided, and review of individuals' records that the required aspects for managing the Infection Control Program were consistently, thoroughly, and substantively addressed. If this requirement was a standalone Provision, it would continue to be considered in substantial compliance.<br><br><u>Availability of Pertinent Medical Records:</u><br>• Records were made available onsite without difficulty or delay.<br>• The Red Care Plan Books were located in each home. The books were subdivided by individual and contained four sections per individual: The Integrated Direct Support Professional Care Plans, Acute Care Plans, the medication sheet instructions, and the IHCP. This allowed the Direct Care Professionals (DSPs), floor nurses, and RN Case Managers to have ready access to these documents.<br><br><u>Monitoring Team's Independent Review of Mock Medical Emergency Drills and Emergency Response Activities:</u> | |

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| | | Since the last compliance review, the Monitoring Team's independent review of supporting documentation and interviews with the key staff responsible for managing the Emergency Response System found that the Facility continued to maintain the positive practices previously identified to comply with the requirements of the Emergency Response Policy, 044., 9/7/11, as verified through the following:<br>• The Facility continued to have all of the required emergency equipment, including AEDs. They maintained 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. Since the last compliance review, emergency carts, suction machines, and oxygen tanks were placed in the Wooden Nickel and Foster Grandparents areas.<br>• The Safety Specialist continued to complete monthly Emergency Equipment and Automated External Defibrillators (AEDs) Walkthrough Checklists. When problems were identified there was evidence that corrective action was taken.<br>• The Nurse Managers and assigned nursing staff continued daily emergency equipment and AEDs checks per policy. The analysis of the data for completing the daily checklists showed an overall monthly compliance of: 94.7% in July 2013, 94.22% in August 2013, 93.22% in September 2013, 84.22% in October 2013, and 96.78% in November 2013. There was documentation that when the Nurse Managers identified issues with checking the emergency equipment and AED to ensure it was all present and in good working, as well as completed the daily checklists, real time corrective action was taken with the appropriate staff or unit.<br>• Mock Medical Emergency Drills continued to be completed according to the frequently required by policy and schedule. The monthly drill data for the past six months showed that drills were completed and successful consistently with a 95% or greater compliance. The next working day after drills were completed, the results of the drills were reported to IMRT for review and disposition. A review of the IMRT Notes, July 2013 through November 2013, found if there were issues identified by the IMRT, recommendations were made in the notes. Any corrective actions recommended and completed were reported to the IMRT with copies of supporting documentation. For example: On 7/28/13, staff on 511A was not able to perform CPR properly. The staff was not allowed to work alone until retrained. It was reported on 7/30/13, that the drill instructor reviewed with staff on 523D the necessity to remove the victim from the bed to perform compression. The location of the black box (emergency equipment) was clarified. Reviewed the staffs' roles if multiple staff were around because nobody called 3333 after the first responder told them to call until a few minutes had gone by. Everybody thought someone else called. Training records included in the IMRT notes showed retraining was completed on 8/16/13.<br>• The Security Specialist continued to schedule, track, analyze, and provide completed Mock Medical Emergency Drills Reports to the Quality Assurance Department. According to the QA/QI Council meeting, 12/17/13, the drills met 95% or greater compliance, therefore, no CAP was required.<br>• Since the last compliance review, there were no changes made to: The Emergency Response Policy, CPR Training Curriculum, Emergency Response Committee's integrated core membership, or staff responsible for conducting the Mock Medical Emergency Drills.<br>• The CTD Due/Delinquent Training List, printed 12/5/13, for Cardiopulmonary Resuscitation (CPR) Basic showed two employees were delinquent. CPR for Health Care Providers showed one employee | |

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| | | was delinquent. The physician who was delinquent in CPR for Healthcare Providers was scheduled for training on 12/6/13 but there was no documentation provided that showed the training was completed. Overall, this showed 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.<br>• The Monitoring Team's independent interview with key Emergency Response Committee members and review of quarterly Emergency Response Committee Meeting minutes, 9/23/13 and 12/3/13, showed the Committee reviewed and critiqued all types of drills performed at the Facility, including Mock Emergency Drills, Code Blue Events, Fire Drills, and Tornado Drills. The Safety Specialist identified problems with the emergency cart seals. The original break away locks were easily broken leaving the carts unlatched. As a result stronger locks were procured and used to secure the emergency cart. It was positive to find that the committee identified the need for emergency equipment in the Wooden Nickel and Foster Grandparent because of the distance located away from the main buildings. Hence, the equipment was placed in these areas.<br><br>As a result of an improper response to a Code Blue Event that occurred during the last compliance review, the committee reported that the Mock Medical Emergency Drills routinely included the scenario for CPR with the victim in bed with the side rails up, as well as other scenarios that may require emergency response. Two Code Blue Events occurred on 11/11/13 and 12/2/13; the Committee related the events that contributed to the staff's prompt response to provide CPR and successful resuscitation efforts to the code events. Based on the Committee's reports of the events and supporting documents reviewed, it appeared that corrective actions taken since the last compliance review were effective in improving response to medical emergencies.<br><br>The Facility should continue the positive practices identified in the Emergency Response System report. If Emergency Response Activities were a standalone requirement it would be considered in substantial compliance with the Emergency Response Policy requirement for this Provision.<br><br>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. The Facility's Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. | |
| M2 | Commencing within six months of the Effective Date hereof and with full implementation | <u>Monitoring Team Findings:</u><br>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; interviews with Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, RN Case Manager Supervisor; review of documents requested; and review of active 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 | Noncompliance |

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| | 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. | findings.<br><br><u>New and/or Revised for Nursing Assessment Policies, Procedures, and Guidelines:</u><br>• DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Date: September 2013<br><br><u>Training Activities for RN Case Managers:</u><br>• All 28 RN Case Managers were trained on the DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment.<br>• For other nurses' training refer to Provision M.4.<br><br><u>Nursing Administration Activities:</u><br>• Implemented the state's standardized Annual Comprehensive Nursing Assessment format and the Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment.<br>• The RN Case Manager Supervisor was in the process of revising/updating the Annual Comprehensive Nursing Assessment Monitoring Tool and developing a process for monitoring data longitudinally. Each item on the monitoring tool was weighted with a score of one to five based on its significance. Nursing Administration expected that improvements made in the accuracy and timely completion of the Annual Comprehensive Nursing Assessment will also impact the completion and improvement of the Quarterly Nursing Reviews and Physical Assessments, as well as decrease the amount of time needed to make changes once the annual reviews are completed appropriately. The monitoring tool that was being revised/updated was not yet finalized. It was projected to be implemented by the end of January 2014.<br>• Timely submission of assessment audits for ISPs was completed by the QA Director. For assessments falling below the desired threshold for timeliness, the QA informed the respective disciplines that a CAP was required. The Timeliness of Assessment for ISP Audit in October 2013 found Nursing fell below the desired threshold. The RN Case Manager Supervisor initiated a CAP related to timeliness of completion of comprehensive nursing assessments that remained open at the time of the compliance review.<br><br><u>Monitoring Team's Review of Recently Completed Comprehensive Nursing Assessments and/or Review/Quarterly Nursing Record Review/Quarterly Physical Assessments</u>:<br>Since June 2013, the state's nursing assessment forms and instructions had changed twice. In June 2013 the Comprehensive Nursing assessment Policy was changed to the Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment and in September 2013, the Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment was revised again when the state's standardized annual nursing assessment was implemented. Each time there was change to the nursing assessment forms and instructions the RN Case Managers had to be retrained to adapt to the changes. Therefore, it required time for the learning curve to take place, which had an impact on the timeliness and accuracy of the nursing assessments. | |

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| | | In addition, there were other factors that impacted the RN Case Managers' ability to complete the nursing assessments timely. Nursing Administration reported that over the past six months, six of 28 (22%) RN Case Managers had resigned. In the interim, while vacant RN Case Manager positions were being filled and/or while the newly hired RN Case Managers were in orientation, the remaining RN Case Managers had to pick up the vacant caseloads until the newly hired RN Case Managers took over the caseloads. This significantly increased the workload of each RN Case Manager. At the time of the compliance review, all RN Case Manager positions had been filled. Other issues that affected the timeliness of completing the nursing assessments included: Problems with the computers, i.e., the band width caused loss of documents. The moving of ISP dates indirectly affected the completion of the nursing assessment; while the changes of ISP dates were not factored in the QA Director's timeliness audits, the moving of the ISP dates could have affected the RN Case Managers' ability to complete several nursing assessments due at the same time.<br><br>Although the revised nursing assessment forms and instructions were similar, there was enough variation to make it difficult to accurately determine the quality of the assessments' content. Therefore, because of the issues mentioned above, only the most recently completed admission, annual and quarterly nursing assessments were reviewed since the implementation of standardized nursing assessment form and DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment in September 2013.<br><br>The Monitoring Team reviewed the most recently completed Admission, Annual Comprehensive Nursing Assessments, and/or Quarterly Nursing Reviews and Physical 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 14 Individuals: #567, #519, #326, #187, #243, #800, #286, #668, #616, #425, #28, #459, #666, and #583, and found:<br>• Three of three (100%) Annual Comprehensive Nursing Assessments were completed timely, within 10 days of the ISP meetings.<br>• Four of four (100%) New Admission Nursing Assessments were completed timely, within 30 days of admission.<br>• Five of seven (71%) Quarterly Nursing Assessments were completed by the last day of the month that the quarterly was due.<br><br>The nursing assessments were reviewed for compliance against current standards of practice, i.e., DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment.<br>• Thirteen of fourteen (93%) nursing assessments requested for off-site review were provided.<br>• A review of the 13 admission, annual and/or quarterly nursing assessments found an overall compliance score of 79% compliance with the DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. However, for the admission and annual nursing assessments a compliance score of 90% was found with the guidelines. For quarterly nursing assessments a compliance score of 67% was found with the guidelines. It appeared | |

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| | | that the efforts for improvement that were put forth by the RN Case Manager Supervisor on the timeliness of completion of the admission and annual nursing assessment were beginning to show effectiveness. The primary factors that led to an overall low compliance score for the quarterly nursing assessment included: Missing Quarterly Nursing Reviews and/or Quarterly Physical Assessments, failure to sufficiently summarize individuals' response to care plans for high and/or medium risk or other identified nursing problems, and failure to state the effectiveness of the care plans. It is expected with the continued monitoring and oversight by the RN Case Manager Supervisor there will be continued improvement found in the nursing assessments at the next compliance review.<br><br>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 monitoring completed nursing assessments using the new guidelines and forms, as well as providing feedback to the RN Case 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. The Facility's Self-Assessment stated they were not in compliance with this Provision and the Monitoring Team concurs.<br><br>Refer to Provision M.5 for report on IRRFs and HICPs. | |
| 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 | <u>Monitoring Team's Findings:</u><br>The Monitoring Team independently 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; interviews with Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, and RN Case Manager Supervisor; review of documents requested; and review of individuals' active 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.<br><br><u>Nursing Training Activities:</u><br>• Refer to Provision M.4 report for information on training.<br><br><u>Nursing Administration Activities:</u><br>Since the last compliance review, through interviews with the Nursing Administration/Management staff and review of documents provided, the following additional activities had been performed:<br>• One significant change that had taken place on 1/6/14 was the discontinuation of the generic acute care plans. Acute Care Plans have been updated by the state office to now include a blank shell and an intervention bank for different types of care plans. The purpose of the updated care plan process was to facilitate the individualization of care plans. A bank of approximately eleven interventions had been developed to date, with more to be developed, from which nursing could draw when developing acute care plans. | Noncompliance |

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| | subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised. | • The Acute Care Plan audits were implemented based on the eight protocol cards being audited. This was a new process for auditing Acute Care Plans and was continuing to be reviewed and refined to ensure reliability. At the time of the review, Acute Care Plan audits were in the process of being analyzed. According to the Action Plans CV7, the analysis was to be completed 1/13/14. Therefore, no Acute Care Plan data was available to review. The Monitoring Team will review the results of Acute Care Plan audit data at the next compliance review.<br>• The Section I Monitoring Tool was not utilized by the Nursing Department. The QA Department completed this tool as assigned. The monitoring data were presented during the QA/QI Council meetings for the appropriate sections. Through the use of this monitoring tool a work group was established to address the Integrated Support Plan (ISP) participation and a CAP was developed and was in the process of being trained and implemented. As a result of the CAP, the RN Case Manager Supervisor provided training to all of the RN Case Managers and some of the Specialty Nurses. It was expected that the work group did not foresee a quick improvement in the ISP, Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) process, however; the progress will continue to be measured through the QA process. The Monitoring Team was not provided a copy of this information to review.<br>• The Individual Notebooks do not contain the Integrated Direct Support Professional Care Plans. The Facility decided to place them in the Red Care Plan Books in the homes. The books were subdivided by individual and contained four sections per individual: The Integrated Direct Support Professional Care Plans, Acute Care Plans, the medication sheet instructions, and the IHCP. This allowed the Direct Care Professionals (DSPs), floor nurses, and RN Case Managers to have ready access to these documents.<br>• At the time of the compliance review, there was no monitoring tool in place for nursing related to Community Living Discharge Planning (CLDPs). Nursing Administration was in the process of developing guidelines for CLDP. These guidelines will be finalized and provided to the RN Case Managers by 2/28/14.<br><br><u>The Monitoring Team's review of Skin Integrity Acute Care Plans (ACPs) and Integrated Health Care Plans (IHCPs):</u><br>The Monitoring Team independently reviewed the Skin Integrity ACPs, IHCPs and accompanying documentation for Individuals: #423, #187, #286, #86, and #129, and found significant improvement in content and quality from the previous compliance review. The improvements appeared related to the Skin Integrity Nurse's oversight in the development and review/revision of the care plans.<br>• Five of five (100%) ACPs were initiated upon diagnosis of the pressure wounds.<br>• Five of five (100%) ACPs contained baseline data that succinctly described the condition that lead to the necessity for the care plans.<br>• Five of five (100%) ACPs were individualized sufficiently to meeting the individuals' health care needs.<br>• Five of five (100%) ACPs contained clinically sound and appropriate immediate and proactive interventions to resolve and/or prevent future occurrence of skin integrity issues. Although the ACPs used the generic care plan template, they were modified by striking thorough actions/interventions that were not applicable and by writing in actions/interventions that were applicable. Treatment regimens | |

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| | | were included specific to the individuals' physician orders.<br>• Five of five (100%) ACPs were integrated with other relevant disciplines, i.e., Habilitation/PNMPs and Repositioning Schedules posted by Physical Therapists.<br>• Five of five (100%) ACPs specified the frequency actions/interventions were to be performed and the documentation requirements.<br>• Four of four (100%) ACPs that were due for monthly and/or more frequent reviews when indicated were reviewed/revised.<br>• One of one (100%) ACP indicated that the pressure wound was resolved. The other four ACPs remained active.<br>• Five of five (100%) ACPs contained clinically sound and appropriate Direct Care Professional Instruction Sheets. The instructions were written in terms that were easily understood and free from nursing/medical jargon.<br>• Three of five (60%) of the Direct Care Support Professional Instruction Sheets included the signatures validating that Home Managers and Direct Support Professionals were trained on all three shifts. Two Direct Support Professional Instruction Sheets lacked signatures for the 10-6 shifts. It is essential that Home Managers and Direct Support Professional are trained on the Direct Support Professional Instruction Sheets on all shifts.<br><br>The Monitoring Team reviewed the Integrated Health Care Plans (IHCPs) for Skin Integrity for Individuals: #187 and #423 who had had high risk ratings for chronic skin integrity issues, and found:<br>• Two of two (100%) IHCPs had clinically sound and appropriate proactive/preventative nursing interventions, including the responsible nurses, frequency of monitoring and location of documentation, and RN Case Managers responsible for review of progress and efficacy of plans. However, the proactive/preventative nursing interventions were briefly stated. The proactive/preventative nursing interventions should contain more specificity as to the actions to be taken.<br>• Two of two (100%) IHCPs had Integrated Direct Support Professional Instruction Sheets that were clinically sound and appropriate for their proactive/preventative skin care responsibilities.<br>• Two of two (100%) Integrated Direct Support Professional Instruction Sheets included signatures for the Home Managers and Direct Support Professionals on the 6-2 shifts and 2-10 shifts. Zero of two (0%) contained signatures for the Home Managers and Direct Care Professionals on the 10-6 shifts.<br><br>The Monitoring Team requested copies of skin integrity pressure wound related ACPs, and/or IHCPs, Integrated Progress Notes, accompanying Physician Orders and any other associated documentation for offsite review. All of the copies for four of five individual's records requested were provided. For Individual #129, only the Skin Integrity Nurse's Integrated Progress Notes were provided with an occasional nursing note included. The Skin Integrity Nurse and nurses' Integrated Progress Notes showed individuals that assessments and treatments were carried out according to the plans of care. Notes showed that the wounds were thoroughly and accurately assessed and documented as well as the treatments applied. There was documentation in the Integrated Progress Notes that wound care instructions were provided to the respective nursing staff and direct support professionals. The Skin Integrity Nurse stated she preferred | |

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| | | documenting skin integrity assessments, treatments, and status of wound healing in narrative notes as opposed to using the Pressure Ulcer Scale for Healing (PUSH) and/or E-Z Graph Wound Assessment System for documenting the status of wounds. A nursing protocol card for skin integrity issues has not been developed. The development and implementation of a protocol card for skin integrity would be helpful in prompting nursing staff on the assessment and management of wound care.<br><br>The Integrated Progress Notes included documentation of the Skin Integrity Nurse's visits to individuals in the hospitals and LTAC facility, along with evidence of collaboration regarding care with their wound care nurses, as well as the accompanying individuals to Wound Care Specialist appointments. There was documentation that the Skin Integrity Nurse consistently kept the respective primary care providers, respective nursing and direct support professionals, and other relevant interdisciplinary team members informed of status of the wound assessments and response to treatments.<br><br><u>The Monitoring Team's Review of Urinary Tract Infection (UTI) Acute Care Plans (ACPs):</u><br>The Monitoring Team's review of a sample of five individuals with recent and/or current active Urinary Tract Infections Acute Care Plans and supporting documentation for five individuals with recent and/or current active UTI Acute Care Plans for infections: Individuals #668, #28, #187, #507, and #612. This review found that only three of five (60%) had care plans developed and implemented. A review of the three UTI Acute Care Plans found:<br>• Two of three (67%) plans had baseline data sufficient to identify how the UTI led to the necessity for care plans.<br>• Two of three (67%) plans had goals sufficient to identify the desired outcomes of the UTIs for which the care plans were designed to resolve.<br>• Zero of three (0%) plans were individualized sufficient to meet the individuals' care for UTIs. The plans were copied directly from the generic card plans without modification to individualize.<br>• Zero of three (0%) plans incorporated Nursing Protocols for UTI, Antibiotic Therapy, Pain, and/or other relevant protocols.<br>• One of three (33%) plans included notification of the Infection Control Preventionist of the UTI.<br>• Zero of three (0%) plans included the frequency interventions were to be completed, by whom, and where documented.<br>• One of three (33%) plans showed they were reviewed/revised when interventions/treatments for UTIs were changed, when applicable.<br>• One of two (50%) plans contained documentation when UTIs were resolved, as applicable.<br>• One of three (33%) plans contained signatures verifying that the respective Home Managers/Charges and DSPs on all three shifts were trained on the DSP Instruction Sheet.<br><br>Review of Individuals: #668, #28, #187, #507, and #612 Integrated Progress Notes found:<br>• Five of five (100%) individuals' Integrated Progress Notes contained consistent documentation of assessment and other interventions as required by relevant nursing protocol cards, i.e., When Contacting PCP, Urinary Tract Infection, Antibiotic Therapy, and Pain, as well as instructions to the | |

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| | | DSPs. There was documentation daily on each shift from the onset of the infection through to resolution and/or to date.<br><br><u>Monitoring Team's Review of Reportable Infectious/Communicable Disease Acute Care Plans (ACPs):</u><br>The Monitoring Team's review of a sample of five individuals with recent and/or current active Reportable Infectious/Communicable Disease Acute Care Plans and supporting documentation for Individuals: #32, #719, #218, #86, and #587 found:<br>• Of the five individuals with recent and/or current active Reportable Infectious/Communicable Disease Acute Care Plans for infections, four of five (80%) had care plans developed and implemented. A review of the four Acute Care Plans found:<br>o One of four (25%) plans had baseline data sufficient to identify how the Reportable Infectious/Communicable Disease led to the necessity for care plans.<br>o One of four (25%) plans had goals sufficient to identify the desired outcomes of the Reportable Infectious/Communicable Disease for which the care plans were designed to resolve.<br>o Four of four (100%) plans did contain relevant interventions sufficient to meet the individuals' care for reportable infectious/communicable diseases.<br>o Zero of four (0%) plans incorporated Nursing Protocols for Antibiotic Therapy, Pain, Skin Integrity, C-diff and MRSA relevant protocols.<br>o Four of four (100%) plans included notification to the Infection Control Preventionist of the reportable infectious/communicable diseases. Two of four (50%) individuals' records contained Infection Control Notes by the Infection Control Preventionist that showed that plans were reviewed.<br>o Zero of four (0%) plans included the frequency for all of interventions to be completed, by whom, and where documented.<br>o Four of four (100%) plans contained documentation when resolved.<br>o One of four (25%) plans contained signatures verifying that the respective Home Managers/Charges and DSPs on all three shifts were trained on the Direct Support Professional Instruction Sheets.<br><br>Review of Individuals: #32, #719, #218, #86, and #587 Integrated Progress Notes found:<br>• Four of five (80%) individuals' Integrated Progress Notes contained consistent documentation of assessments and interventions as required by relevant nursing protocol cards, i.e., When Contacting PCP, Antibiotic Therapy, and Pain, as well as instructions to the DSPs. There were documentation notes daily/shifts for each individual from the onset of the infection through to resolution and/or to date. The Integrated Progress Notes for all five individuals were consistently written in the SOAP format. Individual #587 records showed that the relevant protocols were not consistently followed. For example:<br>o Individual #587's g-tube soma site was assessed to have yellowish drainage with a foul odor on 6/30/13 (Sunday) and again on 7/1/13. On 7/1/13 the nurse referred Individual to clinic for assessment of the yellowish drainage with foul odor from the stoma site. There was no documentation found that showed Individual #587 was seen in clinic. Daily on every shift, | |

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| | | 7/2/13 through 7/10/13, the nurses continued to assess the stoma site and document signs of infection and purulent drainage from the stoma site. It was not until 7/10/13, when the Skin Integrity Nurse assessed the stoma that the primary care provider was notified of the drainage from the stoma and a culture of the drainage was ordered for the morning of 7/12/13. The culture results were reported on 7/15/13 as positive for MRSA. Susceptible antibiotics were prescribed and started to treat the MRSA on 7/15/13. The Integrated Progress Notes reviewed, 7/15/13 through 7/26/13, showed that the nursing staff implemented an ACP and followed the Antibiotic Therapy and MRSA protocols daily on each shift through to resolution on 7/26/13. The Monitoring Team was concerned by of the lack of the nursing staff and primary care provider's sense of urgency and prompt attention to the purulent stoma drainage from the first signs of infection reported on 6/30/13, until a culture was performed and treatment was prescribed on 7/15/13. The delay in treatment had the potential to worsen the stoma infection that could have led to a more systemic condition like sepsis and the spread of MRSA to other individuals.<br><br>As was found in previous compliance reviews, the Acute Care Plans showed no improvement in the development and implementation of care plans that were sufficiently individualized, as well as in the content and quality to provide guidance in the assessments and management of individuals' care of infections. However, the documentation reviewed in the individuals' Integrated Progress Notes above was far more complete and comprehensive regarding assessments and management of infections according to related protocols for specific infections. There appeared to be some confusion regarding when to initiate an ACP as opposed to initiating Nurse Watch. This should be clarified with the nursing staff. If care plans are to be used functionally, they should include all actual individualized interventions and should be revised consistently as the status and/or interventions/treatment regimens change. Care plans should not merely be a perfunctory paper exercise. 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. Nursing should ensure that the Home Managers/Charges and DSPs are trained on the Direct Support Professional Sheets on all three shifts. Perhaps the revised Acute Care Plan Process implemented in January 2014 will improve the individualization, content, and quality of the care plans. The Monitoring Team will review the Acute Care Plans for progress/improvement at the next compliance review.<br><br><u>Monitoring Team's Review of Nursing Discharge Summaries and Community Living Discharge Planning Packets:</u><br>The Monitoring Team reviewed five Nursing Discharge Summaries and Community Living Discharge Planning Packets for Individuals: #611, #171, #686, #320, and #238, and found:<br>• Five of five (100%) Nursing Discharge Summaries were completed within 45 days of discharge.<br>• Five of five (100%) Nursing Discharge Summaries included individuals' assessments, clinical services' needs, and health status in relation to each significant identified health clinical indicators, such that the receiving agency could understand their present health status in order to respond to their health care needs. | |

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| | | • Four of five (80%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' preferences.<br>• Five of five (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Special Instructions.<br>• Two of five (40%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' medications.<br>• Four of five (80%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Immunization Records<br>• Two of five (40%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' MOSES/DISCUS, as applicable.<br>• One of five (20%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IRRF.<br>• One of five (20%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IHCP and/or other related health care plans, as needed.<br>• Two of five (40%) Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' DSP Instruction Sheets.<br><br>The Facility's Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. Nursing Administration was in the process of implementing and training the RNs on the new Acute Care Plan process, which should improve the individualization, content and quality of the care plans. In addition, Nursing Administration was in the process of developing guidelines for Community Living Discharge Planning. As the new processes are fully implemented, they should move this Provision forward toward compliance.<br><br>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 | <u>Monitoring Team's Findings:</u><br>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. As noted below, the Facility has revised nursing audits to provide information on implementation of protocols; the Facility will need to act in a timely manner if information from these audits indicates a need for improvement.<br><br><u>Annual Nursing Competency Training, New Nurse Education Orientation and Supplemental Training</u> | Substantial Compliance |

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| | sufficient to address the health status of the individuals served. | Reports:<br>• The Nurse Educators continued to maintain an excellent, comprehensive, and up to date Nursing Training Database that indicated the percentage of the nurses that had completed the required training, as well as for nurses who had not completed the training, with projected dates for completion. The database included the overall percentages of nurses trained to date.<br>• The required Annual Nursing Competencies were taught monthly to incumbent nursing staff throughout the year as well at new Nurse Education Orientation (NEO). Nursing Education provided opportunities for make-up classes to incumbent nurses during NEO. 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. Annual retraining was scheduled for 1/27/14.<br>• The chart below reflects the status of Annual Nursing Competency Training completed through to 1/15/14. The chart below showed that the nursing staff had completed all annual nursing competency-based training requirements. All were completed by 95% or greater: | |

| Annual Competencies as required by Competency Based Training Policy | RN Core Numbers | Percent Trained | LVN Core Number | Percent Trained | Completion Date or Projected Completion Date | Protocol Cards Integrated |
|---|---|---|---|---|---|---|
| Skin Management and Wound Care | 108 | 100% | 83 | 100% | Completed - Ongoing with NEO | 1 |
| Diastat/REACT Score | 108 | 98% | 83 | 99%% | Completed - Ongoing with NEO | 1, 9, and 20 |
| G-tube Insertion/Stoma Care | 108 | 100% | 83 | 100% | Completed - Ongoing with NEO | 4 |
| Neurological Assessment | 108 | 99% | 83 | 100% | Completed - Ongoing with NEO | 15 and 1 |
| MOSES/DISCUS Training for RN Case Managers | 28 | 100% | N/A | N/a | Completed - Ongoing with NEO | N/A |
| Urine/Dipstick/Hemoccult | 108 | 99% | 83 | 100% | Completed - Ongoing with NEO | N/A |
| Hospital/Discharge/Transfer | 108 | 99% | 83 | 100% | Completed - Ongoing | 23 and 1 |

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| | | | | | | | with NEO | |
| | | RN - Acute Care Plans | 108 | 100% | N/A | N/A | Completed - Ongoing with NEO | 1 plus specific issues |
| | | LVN - Acute Care Plans | N/A | N/A | 83 | 100% | Completed - Ongoing with NEO | 1 plus specific issues |
| | | Constipation Protocol | 108 | 100% | 83 | 95% | Completed - Ongoing with NEO | 13 and 11 |
| | | TD Clinical Manifestation – MOSES/DISCUS (Non RN Case Managers) | 80 | 100% | 83 | 99% | Completed - Ongoing with NEO | N/A |
| | | Medication Calculation Test | 108 | 96% | 83 | 97% | 12/31/14 Ongoing with NEO | N/A |
| | | Procedural Tests | 90 (non-administrative or specialty nurses) | 98% | 83 | 99% | 1/31/14 Ongoing with NEO | All protocol cards |
| | | Adverse Drug Reaction | 108 | 96% | 83 | 100% | 1/31/14 Ongoing with NEO | N/A |
| | | Medication Variance | 108 | 96% | 83 | 100% | 1/31/14 Ongoing with NEO | N/A |
| | | RN Physical Assessment Class/Check Off | 104 | 100% | N/A | N/A | Ongoing with new RNS quarterly. Next class March 2014 | N/A |
| | | MAN0100 Medication Administration for I/DD | 102 | 100% | 80 | 100% | Ongoing with new RNS quarterly. Next class February 2014 | N/A |

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| | | Documentation | 108 | 98% | 83 | 100% | Ongoing with NEO | 1, 11, 12, 13, 14, 15, and 21 | |
| | | Mosby Chapters for RNs: | | | | | | | |
| | | Chapter 17 - Abdomen | 108 | 98% | N/A | N/A | Ongoing with NEO | N/A | |
| | | Chapter 13 – Chest and Lungs | 108 | 98% | N/A | N/A | Ongoing with NEO | N/A | |
| | | Chapter 21 - Musculoskeletal | 97 | 100% | N/A | N/A | Ongoing – rotates quarterly with new RNs | N/A | |
| | | Chapter 22 – Neurological | 97 | 100% | N/A | N/A | Ongoing – rotates quarterly with new RNs | N/A | |
| | | Chapter 14 - Heart | 98 | 99% | | | Ongoing – rotates quarterly with new RNs | N/A | |
| | | Chapter 10 – Head and Neck | 104 | 95% | N/A | N/A | 1/31/14 then quarterly with new RNs | N/A | |
| | | Chapter 12- Ear, Nose, and Throat | | | | | Scheduled for 1/28/14. Last required chapter. | N/A | |
| | | *The protocol cards were numbered and were integrated into the annual competencies as related to the specific competency taught and included in Acute Care Plan training.<br><br>It was positive to find that the Nursing Education Department was now tracking and reporting all in-service training provided in addition to the required annual nursing competencies, regardless of who provided the training. The chart below showed the supplemental training provided to the nursing staff campus wide and | | | | | | | |

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unit specific for 7/1/13 through 12/31/13:

| Training Title | Date of Training | Campus Wide Nurse Training | Unit Specific Nurse Training | Purpose to: |
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| Family/Guardian Refusals of Taking Pass Medication and Medication Pass Return Form | July 2013 through September 2013 | Yes | No | Introduce new Medication Pass Form to be filled out if and when medications are not taken by family on pass so pharmacy can track the information and share if further action is needed. |
| Clostridium Management Protocol | 7/17/13 through 7/31/13 | No | Yes Westridge/Garden Ridge | Discuss purpose of the protocol; define C-diff, management of C-diff in the Infirmary an in the homes. Safe use of bleach by housekeeping staff in the Infirmary and different home. |
| Documentation | 7/17/13 through 7/31/13 | Yes | No | Address identified issues from QA/QI Meeting related to protocol card audit tool and documentation issues. |
| Prevention and Control of Helicobacter Pylori | 8/30/13 | No | Yes | Define Helicobacter Pylori signs and symptoms, duration, diagnosis. How Helicobacter Pylori is diagnosed. How do people get infected with Helicobacter Pylori? Apply infection control guidelines. |
| Medro Dose Pack and Transcription | 9/4/13 through 9/15/13 | Yes | No | Step by step instruction on how to: Transcribe and process order for a Medrol Dose Pack. |
| Vacation Guidelines | 9/4/13 through 9/11/13 | Yes | No | Inform nursing staff of the new vacation guidelines effective 9/1/13. |

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| | | Nursing follow-up and referral to medical providers. | 10/13/13 | No | Yes<br>Westridge and Garden Ridge | Discuss expectation of documentation, follow-up, and referral to medical provider. Refer to Pain Protocol Card and Suspected Fracture/Dislocation Protocol Card. | |
| | | Communication with A specific individual. | 11/5/13 | No | Yes<br>Houston Park | Specific instruction for nurses regarding how to communicate with a specific individual. | |
| | | Full body checks on a specific individual. | 11/14/13 through 11/20/13 | No | Yes<br>Eastfield/Timber Hill | Clarify that only female nurses conduct full body checks on a specific individual to lessen stress in the interactions and modesty. | |
| | | Clinic List Process and Telephone Orders and Verbal Orders | 11/19/13 | No | Yes<br>10-6 Nursing Staff | Train on the use of the Clinic List and Form used for telephone orders and verbal orders. | |
| | | Open versus Closed Feeding Systems. | 11/15/13 through 11/22/13 | No | Yes<br>Cedar Falls and Houston Park | Educate nurses on the difference in an Open versus Closed Tube Feeding System (Ready to hang bottles/E-pump Safety Screw) | |
| | | Reminders regarding Liquid Medications. | 12/4/13 through 12/16/13 | Yes | No | Retrain nurses on liquid medications: Date bottles when opened, send to Infirmary for observation and admission, return to home on discharge. Liquid prescription med is dosed from individual's own bottle that has a pharmacy label. | |
| | | Saphris Medication | 12/13/13 through | Yes | Yes<br>Eastfield/Timbe | Train nurses on specifics of administration and side | |

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| | 12/16/13 | | r Hill | effects. |
| Prevention and Management of a specific individual's behaviors. (Behavioral Services) | 12/5/13 through 12/16/13 | No | Yes Westridge | Detailed instructions on the prevention and management of a new individual. |
| Instructions regarding checking the oven prior to use. | 12/13/13 through 12/16/13 | Yes | No | Check oven prior to putting anything in the oven. Do not place plastic ware, rubber maid ware or any non-oven ware in the oven or stove. |
| Section C Restrain (Nursing and Medical) | 12/18/13 | No | Yes (specific nurse) Eastfield/Timber Hill | Instructions for assessment after restraint and appropriate documentation. |
| Procedure to following case of fire. | 12/19/13 | No | Yes (specific nurse) Eastfield/Timber Hill | Procedures to follow in case of fire. |

<u>Summary of Nursing Education activities, July 2013 through January 2014, in addition to routine orientation and annual competency training:</u>

- In August 2013 and November 2013, the Nurse Educators participated in a state wide committee of Nurse Educators to improve the Nurse Education Handbook. The Monitoring Team reviewed the proposed revisions/improvements with the Nurse Educators, which were to take effect in January 2014. One significant change that had taken place on 1/6/14 was the discontinuation of the generic acute care plans. Acute Care Plans have been updated by the state office to now include a blank shell and an intervention bank for different types of care plans. The purpose of the updated care plan process was to facilitate the individualization of care plans. A bank of approximately eleven interventions had been developed to date, with more to be developed, for which nursing could draw from when developing Acute Care Plans. At the time of the compliance review, the Nurse Educators reported that approximately 58 of 108 (54%) nurses had been trained on the new care plan process.
- Precepted an RN to Bachelors of Nursing (BSN) student enrolled at Texas Woman's University. Designed a clinical experience curriculum to be used for future BNS students. The student made notable contribution during the Fall 2013 semester. Most notably was an Evidenced Based Practice Self-paced Training Module, which was presented at the statewide Nurse Educator Conference in November 2013, as a possible statewide I-learn computer based training system.
- Trained seven more preceptors that were recommended as high performing nurses by their Nurse Managers. The purpose of having trained preceptors was to have skilled and competent nurses to

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| | | mentor the new nurses, to reinforce the orientation training, assist them in the developing competent nursing skills, and to help foster retention. The Nurse Educators believes the preceptor program has improved retention, however; there were no data provided to verify their beliefs. The Nurse Educators in collaboration with Nursing Administration should consider analyzing nursing retention data to determine the effectiveness of the preceptor program.<br>• Trained two more Nurse Educators from other state supportive living centers, for a total of seven Nurse Educators from the 13 centers.<br>• The Nurse Educators, CNE, and NOO, attended the First Annual Educational Conference sponsored by the Central Texas Chapter of Developmental Disability Nurses Association (DDNA), entitled, "Issues in Evaluation and treatment of Individuals with Developmental Disabilities. In addition, the RN to BSN student who was precepted joined DDNA and became a Certified Developmental Disability Nurse (CDDN). This nurse was employed as a RN Case Manager at the Facility.<br><br>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, head injury, 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. A death that occurred during the compliance visit led to questions about whether a nursing protocol was followed, but information was not yet available at the time of this visit to determine whether this was the case; this will be reviewed at the next compliance visit.<br><br>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, review of individuals' active records, and review of training documents to verify that the Nursing Department had continued to maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.<br><br><u>Audits of Implementation of Nursing Protocols</u><br>The Facility was in process of revising its nursing audits to be consistent with statewide audit tools and to monitor implementation of nursing protocols. Data on implementation of nursing protocols will be reviewed at the next compliance visit. Continuing compliance will be dependent on audit data showing adequate implementation (generally meaning at least 90%, or, if lower, documentation of corrective action followed by improvement to 90%).<br><br><u>Conclusion</u><br>The finding of substantial compliance was maintained. The Facility is providing ongoing training. As documented in other provisions of this Section, review of documents and observation of practice verified that protocols were generally followed. A death led to a question about whether a protocol was followed. | |

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| | | The Facility audits did not provide information on implementation of nursing protocols. At the next visit, review of both whether a protocol was followed during the circumstances of a death and the results of audits of implementation of protocols will provide additional information to consider in determining whether this provision will remain in substantial compliance. | |
| M5 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual. | <u>Monitoring Team Findings:</u><br>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; interviews with the Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, and RN Case Manager Supervisor; review of documents/records requested; attendance at an ISP and ISPA Meetings. 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.<br><br><u>New/Revised Polices, Procedures, Processes, Plans:</u><br>• Risk Action Plan and Clinical Indicators/Data Considerations, no date<br><br><u>RN Case Managers' Training Activities:</u><br>• In September 2013, the RN Case Manager Supervisor provided training to all 28 RN Case Managers training on the IRRF process.<br>• On October 29, 30, and 31, 2013, the RN Case Manager provided training to the 28 RN Case Managers on the Pre-ISP, Post-ISP, and Change of Status (CoS) processes. This included training on the use of clinical indicators.<br><br><u>Nursing Administration Activities:</u><br>• In November 2013, the Facility formed a work group, for which Nursing Administration was included, to address participation in the ISP, IRRF, and IHCP processes. A CAP was developed by the work group to implement steps to improve or build upon the current understanding of the processes. The work group stated that it was expected it to take up to nine months before consistent improvement was seen.<br>• The IRRFs were drafted by the respective RN Case Manager with input from other relevant IDT members to be presented/reviewed at individuals' ISP meetings. The recommendations for individuals' IHCPs were discussed and developed by the IDT during the ISP meetings.<br>• Nursing Administration did not have a monitoring tool specific for nursing. The Section I Monitoring Tool was completed by the QA Department. The monitoring data were presented during the QA/QI Council meetings for the appropriate sections.<br><br><u>Monitoring Team's Independent Review of IRRFs and HICPs:</u><br>The Monitoring Team independently reviewed IRRFs and IHCPs of a sample selected from the Facility's At Risk List for individuals identified at high risk health conditions and from each unit for 10 Individuals: #616, #326, #187, #243, #800, #668, #425, #459, #666, and #583. | Noncompliance |

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| | | The Monitoring Team's focus was on nursing responsibilities related to IRRFs' and IHCPs' for specific high/medium condition risk ratings. Because the IRRFs were an integrated collaboration of all disciplines it was often difficult to accurately discriminate what was actually clinical data entered by nursing versus other IDT member's clinical data to determine the levels of risks for conditions contained within the various risk groups. New admission and annual nursing assessments were completed before the IDT finalized the IRRFs and IHCPs. Therefore, the nursing problems/diagnoses and nursing related portion of the assessment were not yet completed. It would not be until the first Quarterly Nursing Record Review/Quarterly Physical Assessments were completed that determination for compliance with this requirement could be made.<br><br>A review of 10 individuals' IRRFs and IHCPs determined to be at risk, i.e., Individuals #616, and #187, for skin integrity; Individuals #666, #800, and #326 for constipation/obstruction; Individuals #425 and #243 for gastro intestinal disease; Individual #583 and #459 for weight; and Individual #668 for diabetes, found:<br>• Ten of 10 (100%) IRRFs were completed at the time of the ISP meetings.<br>• Five of 10 (50%) IRRFs showed that all relevant clinical data and clinical indicators were included sufficient to make accurate determination of risk ratings, in accordance with the Facility's Risk Action Plans and Clinical Indicators/Data Considerations.<br>• Eight of 10 (80%) IRRFs showed that all relevant disciplines were included in the decision making process for determining each risk rating.<br>• Ten of 10 (100%) IHCPs were developed for all identified high and/or medium risk ratings.<br>• Ten of 10 (100%) IHCPs were implemented within 14 working days, unless there was a justified reason for delay, or were ongoing plans.<br>• Six of 10 (60%) IHCP goals/clinical indicators were observable and/or measurable for each identified risk rating.<br>• Seven of 10 (70%) IHCPs included proactive/preventative and maintenance nursing interventions/protocols sufficient to meet the health care needs for each identified risk rating. However, even the proactive/preventative and maintenance nursing interventions/protocols that appeared sufficient to meet individuals' needs were written briefly and lacked specificity in both the IHCPs and ISPs. It was positive to find that the relevant nursing protocols for acute events were beginning to be included in the IHCPs.<br>• Ten of 10 (100%) IHCPs proactive/preventative and maintenance nursing interventions/protocols included the dates of implementation, persons responsible, monitoring frequency, and location of documentation for performing each proactive preventative and maintenance nursing interventions/protocols. In reviewing individuals' Integrated Progress Notes and/or other designated documents it was difficult to find or to determine the efficacy of the planned nursing proactive/preventive and maintenance interventions/protocols.<br>• Ten of 10 (100%) Integrated Direct Support Professional Instruction Sheets were developed sufficiently for each relevant identified risk rating.<br>• One of 10 (10%) Integrated Direct Support Professional Instruction Sheets showed signatures to | |

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| | | validate that Home Managers/Charges and DSPs were trained on all three shifts. The most frequently missing signatures were on the night shifts. It is essential that the Home Managers/Charges and DSPs are trained on all three shifts if the individuals' care needs are sufficiently met. The review of the Integrated Direct Support Professional Instruction Sheets typically found signatures for the Home Managers/Charges and DSPs on the first and second shifts.<br>• Ten of 10 (100%) IHCPs were attached to individuals' ISP. However, a review of the ISPs found that seven of ten (70%) had incorporated the planned nursing proactive/preventative interventions/protocols into the body of the ISPs. In three (30%) of the ISPs all of the planned interventions/protocols were not consistently copied into the ISPs as stated in the IHCPs.<br><br>The RN Case Managers were responsible for drafting the IRRFs to present at the ISP meetings. If relevant disciplines do not put their clinical data into the drafts prior to ISPs meetings, the data does not reflect their area of expertise and limits the integrated process of accurately identifying all risk factors. When additional data is presented during the ISP meetings it slows down the meetings. It is essential that all relevant disciplines provide their data timely for the RN Case Manager to put into the draft IRRFs. In order to help expedite the ISP meetings, the Facility should consider implementing draft IHCPs. When IHCPs are developed after the meetings there is the potential that some of the recommendations for the IHCPs to be lost or omitted in the final IHCPs.<br><br>In general, as was found in past compliance reviews, there was wide variation from unit to unit and within 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. The IDTs need to continue 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. The IDTs need to ensure that all relevant clinical indicators are considered when developing risk ratings, as well as including clinical indicators to be measured within plans for risk ratings. The Facility's recently developed and implemented Risk Action Plan and Clinical Indicators/Data Considerations guidelines should assist the IDTs in ensuring all relevant clinical indicators are considered when identifying risk ratings and measurement to include in the plans. The Monitoring Team will follow-up on the status and implementation of the IRRF and IHCP processes at the next compliance review.<br><br><u>Monitoring Team's Attendance at ISP and ISPA Meetings:</u><br>The Monitoring Team attended Individual #567's ISP on 1/13/14, for the first part of the meeting. The Monitoring Team left to complete medication observations before the IRRF was reviewed. According to the Monitoring Teams' independent review of Individual #567's Physician's Annual Medical Assessment and Plan, 12/13/13, it was documented that the Iron (Fe) Deficiency Anemia was not an accurate diagnosis and that Hematological issues were suspected. The physician was awaiting the results/recommendation from the Hematologic/Oncology consult. During the part of the ISP meeting attended by the Monitoring Team the above information was not discussed. | |

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| | | During the Monitoring Team's Medication Administration Observation on 1/13/14 at the 4:00 p.m. med pass, when the nurse checked Individual #567's residual, there was approximately 5cc of orange-pink like colored gastric residual returned. Individual #567 had a diagnosis of anemia; of which the origin had not yet been determined. The Monitoring Team expressed the concern that the gastric content had the appearance of potential gastric bleeding. The nurse explained that Individual #567's meals/food intake were by mouth and possibly could have had prune juice or some other food that would have discolored the gastric content. After some discussion, a gastroccult was performed on the gastric content with positive results for blood. The Nurse Manager promptly informed the primary care providers of the positive gastroccult, who ordered labs for a CBC and Chem 7 for the next morning. Individual #567 was placed on Nurse Watch with gastroccults to be performed at each medication pass. The Monitoring Team was provided with documentation of the follow-up actions taken.<br><br>On 1/16/14, the Monitoring Team attended Individual #567's ISPA Change of Status (CoS) for Anemia meeting. All of Individual #567's relevant IDT members attended the meeting. Individual #567's active record was brought to the meeting and often referred to. The primary care provider led the meeting and gave an account of his past and present medical conditions, including efforts made toward determining the underlying cause of the anemia. The IDT actively participated in discussing and reviewing Individual #567's CoS and then, reviewed and discussed revisions to the IRRFs for anemia and fluid imbalance risk ratings, as well as the development of IHCPs to reduce these risks. The risk rating for anemia remained at high risk due to the serious potential for complication related to this risk area. The IDT will ensure that Individual #567's hemoglobin and hematocrit (H/H) levels were closely monitored to ensure that further complications were caught and addressed in a timely manner. The IDT also developed action plans to rule out causes of the blood loss in order to make a more informed decision about the next course of action to take. The risk rating for fluid imbalance was changed from low to medium due to the interrelation between other risk areas. However, there were no further changes made to this risk area because the IDT found that Individual #567 remained stable with current supports as evidenced by no complications with fluid imbalanced. Refer to Section L for additional information regarding Individual #567's high risk for anemia.<br><br>The Facility's Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. | |
| M6 | Commencing within six months of the Effective Date hereof and with full implementation | <u>Monitoring Team's Findings:</u><br>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; interviews with the CNE and NOO, review of documents requested; attendance at the Medication Variance Committee and Pharmacy and Therapeutics Committee Meetings; and conducted Medication Administration Observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial | Substantial Compliance |

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| | in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | compliance with Provision M.6 and the Monitoring Team concurs with their findings.<br><br><u>New and/or Revised Medication Administration Policies and Procedures:</u><br>• DSSLC Nursing Protocol: Enteral Medication Administration, Revised: December 2013<br>• DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy – 27.1, Revised: 11/10/13<br><br><u>Medication Administration Training:</u><br>• Refer to Provision M.4 for training reports regarding medication administration practices.<br><br><u>Pre- Medication Variance Committee, Medication Variance Committee, and Pharmacy and Therapeutic Committee findings:</u><br>• The Monitoring Team's independent review of the monthly Nursing Pre-Medication Variance Committee Meeting Minutes found: Nursing administration continued to conduct monthly Nursing Pre-medication Committee Meetings. The committee was comprised of the ENE, NOO, Compliance Nurse, Unit/Infirmary Nurse Managers, and QA Nurse. In the meetings the Nurse Managers submitted their respective unit/Infirmary Nursing Medication Variance Reports to the committee for further review and discussion. Prior to the Medication Variance Committee meetings they ensured reports were completed correctly and that prompt corrective action was taken for any identified medication variances. Each unit/Infirmary monthly Pre-Medication Variance Report included a narrative that analyzed their medication variances data by describing in detail the Severity Index Category and the type/reason for the medication variances that occurred during the month. The reports also included medication variance conclusions and trends as to whether local or systemic, as well as corrective actions/follow-up taken by the respective Nurse Managers. The unit/Infirmary Nursing Pre-Medication Variance Reports were submitted and reviewed at the monthly Pre-Medication Variance Committee meetings for further review and disposition.<br>• The Pre-Medication Variance Committee was comprised of: The CNE/NOO (facilitator), Unit/Infirmary Nurse Managers, Pharmacy Director and QA Nurse. The committee consistently met monthly. The Monitoring Team's independent review of the Pre-Medication Variance Committee meeting minutes found: Nursing, pharmacy, medical, and dental medication variances were analyzed by Severity Index Category and type/reason for the medication variances that occurred in the previous months, The reports included medication variance conclusions and trends as to whether local or systemic, as well as corrective actions/follow-up taken by the respective discipline. The Monitoring Team's independent review of Nursing Pre-Medication Committee and the Pre-Medication Committee minutes found that the local corrective actions appeared clinically sound and appropriate specific to medication variances reported. There was no systemic medication variances reported that required CAPs. The Pre-Medication Committee Reports were present for review/discussion at the monthly Medication Variance Committee meeting for further review and disposition.<br>• The Medication Variance Committee was comprised of the Pharmacy Director (Chair), Medical Director, CNE, Director of Quality Assurance, Health Service Compliance Coordinator, Center Director, and Residential Services Director. The committee consistently met monthly. The primary care providers no | |

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longer attended the committee meeting. Pertinent information regarding medication variances were reviewed/discussed and corrective action taken when necessary by the Medical Director after the Integrated Morning Report meetings. The Medication Variance Committee minutes showed they reviewed/discussed the medication variance data, issues leading to the medication variances, and the corrective action take, as well as other related medication administration practices. The minutes included updates on the status of old business carried over from previous meetings and when indicated, additional follow-up actions that were planned for unresolved issues. The meeting minutes contained substantive information that clearly described the issues reviewed/discussed and actions taken to resolve issues as necessary. The results of the Medication Variance Committee meetings' were presented at the quarterly Pharmacy and Therapeutics Committee Meetings for further review, discussion, and disposition, as needed. Medication Variance data were reported to the QA/QI Council at dedicated intervals for review and disposition, if indicated.

- The above information was further validated through Monitoring Team's attendance at the Pharmacy and Therapeutics Committee meeting on 1/14/14; and at the Medication Variance Committee meeting on 1/15/14.

Refer to Section N8 for additional information regarding medication administration practices.

Medication Variance Reports:
The Facility continued to have a comprehensive Medication Variance Database for reporting medication variance data. Medication Variance data included Nursing, Medical, Pharmacy, and Dental Departments. 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 July 2013 through December 2013 that had been aggregated, analyzed, trended, along with remedial actions taken to mitigate medication variances and storage issues.

The chart below shows the total number of medication variances by severity index, reported July 2013 through December 2013:

| Severity Index | Unidentified Other | A | B | C | D | E | F | G | H | I | Monthly Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| July | 1 | 125 | 2 | 77 | 1 | 0 | 0 | 0 | 0 | 0 | 206 |
| August | 1 | 132 | 4 | 59 | 1 | 0 | 0 | 0 | 0 | 0 | 197 |
| September | 0 | 152 | 0 | 77 | 0 | 0 | 0 | 0 | 0 | 0 | 229 |
| October | 1 | 115 | 5 | 61 | 5 | 0 | 0 | 0 | 0 | 0 | 187 |

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| November | 0 | 90 | 2 | 42 | 0 | 0 | 0 | 0 | 0 | 0 | 134 |
| December | 0 | 88 | 5 | 42 | 2 | 0 | 0 | 0 | 0 | 0 | 137 |
| Total | 3 | 702 | 18 | 358 | 9 | 0 | 0 | 0 | 0 | 0 | 1090 |

The charts below shows the total number of medication variances by department, reported July 2013 through December 2013:

| Month | Unidentified | Medical | Nursing | Pharmacy | Dental | Other | Total |
|---|---|---|---|---|---|---|---|
| July | 1 | 31 | 83 | 91 | 0 | 0 | 206 |
| August | 1 | 35 | 80 | 81 | 0 | 0 | 197 |
| September | 1 | 63 | 97 | 68 | 0 | 0 | 229 |
| October | 1 | 51 | 84 | 51 | 0 | 0 | 187 |
| November | 0 | 33 | 49 | 52 | 0 | 0 | 134 |
| December | 0 | 30 | 48 | 59 | 0 | 0 | 137 |
| Total | 4 | 243 | 441 | 402 | 0 | 0 | 1090 |

It was evident since the last compliance review; the Facility had continued to accurately report, analyze, and trend discipline specific medication variance data and to take clinically sound and appropriate corrective actions to mitigate medication variances. As the data above showed, all departments were reporting their medication variances, as required; there was a slight decrease in the total number (33) of medication variances compared to the previous six months as continuous improvements were put in place. It would appear that the previous and ongoing corrective actions were demonstrating effectiveness in preventing and/or reducing the incidences of medication variances.

Monitoring Team's Review of Ten Most Recently completed Medication Variance Reports:
The Monitoring Team's review of the Facility's ten most recently completed Medication Variance Reports for Individuals: #695, #752, #214, #760, #336, #483, #781, #628, #497, and #742, found continued 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.

Facility Medication Administration Observations:
The Monitoring Team independently reviewed monthly overall Medication Administration Observation data completed by the Nurse Managers and the inter-rater reliability checks performed by the QA Nurse. In addition to performing inter-rater reliability checks with the assigned Nurse Manager, the QA Nurse summarized monthly findings for items on the Medication Administration Observation Tool that scored less

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| | | than 100% compliance. For those items scoring less than 85% compliance on the monthly tools, the QA Nurse included narrative summaries of findings for local and/or systemic issues and made recommendations for corrective action. This information was reported to the Nursing Pre-Medication Variance Committee, Medication Variance Committee, and Pharmacy and Therapeutic Committee for further review and disposition. The Medication Administration Observation data below shows the overall monthly percentage of compliance with the Medication Administration Observation Tools and level of agreement between the Nurse Managers and the QA Nurse, July 2013 through December 2013: | |

| Month | July 2013 | August 2013 | September 2013 | October 2013 | November 2013 | December 2013 |
|---|---|---|---|---|---|---|
| Percentage of Compliance | 98% | 99% | 97% | 96% | 98% | 98% |
| Inter-rater reliability | 96% | 96% | None Reported | 92% | 91% | 100% |

During the reporting period there were no systemic issues identified that required the development and implementation of CAPs.

Monitoring Team's Independent Medication Administration Observations:
The Monitoring Team conducted medication observation in Cedar Fall at 4:00 p.m. on 1/13/14 and Houston Park at 4:00 p.m. on 1/14/14, accompanied by the NOO and Unit Nurse Managers. Findings of the observations included:

- The nurses observed administered both oral and enteral medication in accordance with current, generally accepted professional standards of safe medication administration practices. Individuals were informed of the medications they were receiving and the purpose of the medications. 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, as well as to ensure adequate liquids were provided after oral administration of medications.
- The nurses consistently reviewed individuals' Physical Nutritional Management Plans (PNMPs) and checked for allergies before administering medication. Medications were administered in accordance with their PNMPs. All individuals' observed had a current PNMP present in their Medication Administration Records (MARs).
- The nurses consistently administered medications at eye level for individuals receiving medications orally. For individuals who received medications via G-tube, the nurses followed the accepted standards of practice for administration. The nurses consistently reminded the DSPs to ensure that individuals remained in an upright position for an hour after receiving medication.
- The DSPs consistently assisted the nurses during medication administration.
- The nursing and DSP staff treated individuals with dignity and respect.

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| | | • None of the areas where medication administration was observed had a dedicated medication room to take individuals for privacy. Individuals who received medications orally and enterally were administered medication in their room with privacy screens used in semi-private rooms. 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.<br>• The MARs contained nurses' signatures on the Universal Signature Sheets.<br><br><u>Issues identified during the medication administration observations:</u><br>• Individual #567: When the nurse checked Individual #567's residual, there was approximately 5cc of orange-pink like colored gastric residual returned. Individual #567 had a diagnosis of anemia; of which the origin had not yet been determined. The Monitoring Team expressed the concern that the gastric content had the appearance of potential gastric bleeding. The nurse explained that Individual #567's meals/food intake were by mouth and possibly could have had prune juice or some other food that would have discolored the gastric content. After some discussion, a gastroccult was performed on the gastric content with positive results for blood. The Nurse Manager promptly informed the primary care provider of the positive gastroccult, who ordered labs for a CBC and Chem 7 for the next morning. Individual #567 was placed on Nurse Watch with gastroccults to be performed at each medication pass. The Monitoring Team was provided with documentation of the follow-up actions taken. It was of concern that the nurse administering the medication did not recognize the potential that the discolored gastric content could be due to gastric bleeding. Had the Monitoring Team not been conducting the observations it is doubtful that this finding would have been reported to the RN and/or primary provider for further assessment. A review of the Nursing Protocol for Enteral Medication Administration, found that the protocol also included the Nursing Protocol for Abdominal Distention/Pain, which included, "Notify the primary care provider of an abnormal findings." However, neither of these protocols explicitly defined "abnormal findings." The nursing staff should be retrained on these protocols with emphasis on recognizing potential signs blood in the gastric contents and how to respond. For additional information regarding the follow-up to Individual #567's anemia and possible gastric bleeding refer to Provision M.5.<br>• Individual #520: Individual #520 was observed to have some expiratory wheezing during the medication pass. The Nurse Manager reported the wheezing to the Charge Nurse who performed a respiratory assessment and called the Respiratory Therapist who administered per necessary (PRN) Albuterol treatment. Individual #520 was also administered Guaifenesin for cough and placed on Nurse Watch. The Monitoring Team was provided with documentation of the follow-up actions taken.<br>• Individual #65: Individual #65's g-tube opening appeared weak and could lead to leaking. The NOO was to have the g-tube checked for replacement.<br><br>The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6; the Monitoring Team found, as in past compliance reviews, that continuous improvements were made in both in medication administration practices and in the Facility's medication variances procedures and processes to | |

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| | | track, analyze and provide local and systemic corrective action plans. Therefore, this Provision was found in substantial compliance. In order for this Provision to continue to meet substantial compliance the positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to mitigate medication variances, i. e, ensuring that the three checks are performed during medication administration and ensuring that individuals that take medications orally are provided an adequate amount of liquids after receiving their medication. Otherwise, the positive medication administration practices and medication variances procedures and processes demonstrated by this Facility were exemplary and should be recognized as such. | |

| SECTION N: Pharmacy Services and Safe Medication Practices | |
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| Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>1. DSSLC Self Assessment, 12/27/2013<br>2. DSSLC Action Plan, 12/5/13<br>3. DSSLC Presentation Book<br>4. DSSLC Pharmacy Policy – 27.1, Medication Variance Tracking and Procedures, Revised: 11/10/13<br>5. July 2013 pharmacy and therapeutic committee meeting minutes<br>6. Summary of anticholinergic usage<br>7. Intraclass polypharmacy reports for 8/2013, 9/2013, 11/2013, and 12/2013<br>8. List of all individuals provided anticholinergic medications<br>9. For Individuals #11, #707, #741, #533, and #472:<br>a. Most recent two Quarterly Drug Regimen Reviews (QDRRs)<br>b. Current medical list<br>c. Most recent medical, and psychiatric annual reviews<br>d. Most recent MOSES and DISCUS assessments<br>10. Alpha list of all individuals on a benzodiazepine<br>11. Data analysis and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use, which accompanied the December 2013 medication order trends for benzodiazepine report<br>12. For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication (Individuals #703, #236, #305, #33, and #483:<br>a. Most recent two QDRRs<br>b. Most recent IRRF<br>c. Current medication list<br>d. Most recent psychiatric assessment<br>e. Most recent annual medical assessment<br>13. December 2013 medication order trends for benzodiazepines report<br>14. List of all individuals on polypharmacy<br>15. For the first five individuals on the list of polypharmacy (Individuals #28, #605, #250, #604, and #165):<br>a. Most recent two QDRRs<br>b. Most recent psychiatric assessment<br>c. Current medication list<br>d. Most recent ISP, or related document the use of polypharmacy<br>16. Pharmacy and Therapeutics Committee (P&TC) meeting minutes, 7/23/2013<br>17. December 2013 polypharmacy meeting minutes<br>18. December 2013 polypharmacy trends data, and trends analysis<br>19. List of all individuals diagnosed with metabolic syndrome<br>20. For Individuals #490, #599, #606, #397, and #791: |

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| | a. Most recent QDRR<br>b. Most recent IRRF<br>c. Current medication list<br>d. Most recent six months laboratory data<br>e. Most recent annual medical assessment<br>f. Most recent psychiatric assessment<br>g. Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome<br>21. List of all stat chemical restraint data, data analysis, summaries, for the use of stat chemical restraints during the reporting period<br>22. Post chemical restraint clinical review form, undated, no identifying information list.<br>23. QDRR for Individual #119, dated 10/10/2013<br>24. For individuals #703, #90, #666, #248, and #185:<br>a. Most recent two QDRRs<br>b. Past six months MOSES and DISCUS assessments<br>c. Most recent 12 months of lab results<br>d. Most recent two EKG reports<br>e. Most recent annual physician summary<br>f. Most recent psychiatric assessment<br>g. Most recent IRRF<br>h. Current medication list<br>i. Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale<br>25. QDRR schedule for past six months and pending six months<br>26. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date<br>27. Alpha list of individuals who were prescribed a neuroleptic and have diabetes<br>28. Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension<br>29. Alpha list of individuals who were prescribed a benzodiazepine<br>30. Alpha list of all individuals with diagnosis of osteoporosis<br>31. Alpha list of all individuals with diagnosis of seizure disorder<br>32. Alpha list of all individuals who were prescribed a new neuroleptic, or increase dose of a neuroleptic, during the reporting period.<br>33. Copy of past six months MOSES and DISCUS assessments for Individuals #666, #251, #800, #629, and #21<br>34. For the first and than every second individual on the list of all medication variances, for a total of ten examples, that occurred during the reporting period (Individuals #367, #292, #425, #292, #581, #75, #667, #222, #136, #212)<br>**People Interviewed:**<br>1. Jana Boone, R Ph, Pharmacy Director<br>**Meetings Attended/Observations:**<br>1. Polypharmacy Committee |

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| | 2. Pharmacy and Therapeutics Committee (P&TC) |
| | **Facility Self-Assessment:**<br>The Monitoring Team concurred with the Facility Self-Assessment with substantial compliance for Provisions N.1, and N.4 through N.8; however, the Monitoring Team does not agree with the Facility's determination of substantial compliance of Sections N.2 and N.3. Regarding Section N.5, the Monitoring Team identified that the Facility was not routinely providing more frequent assessment of tardive dyskinesia following new prescriptions and dose changes; this Section had been found in substantial compliance at the last compliance visit, and the Monitoring Team continued the finding of substantial compliance for Section N.5 but points out the need to do more frequent monitoring as clinically indicated and will consider this issue in reviewing for compliance at future visits.<br><br>Specific to the Self-Assessment for Sections N.2, and N.3, the Facility relied on data; however, the Monitoring Team disagrees with the Facility's determination that the "QDRR content and quality audits showed" greater then 90% compliance throughout the review period; the Monitoring Team determined that the QDRRs did not adequately address standards of documenting efficacy of pharmacotherapy, among other issues. The Monitoring Team does concur with the Facility's Self-Assessment of ensuring timeliness of QDRRs, and that medical providers review QDRRs. The Monitoring Team disagrees with the Facility's Self-Assessment that Section N.3 is in substantial compliance because the Facility ensures "medications are used in a clinically justifiable manner and that risks are reviewed". From its review, the Monitoring Team determined that the Facility did not consistently document risks associated with pharmacotherapy, and did not consistently documented efficacy or lack of efficacy for all medications. |
| | **Summary of Monitor's Assessment:**<br>The Facility continues to enhance efficacious pharmacy services. The Monitoring Team was impressed with the level of review, recommendations, and action plans developed by the pharmacy department, when addressing system and prescriber issues, within the context of polypharmacy and medication variance committee meetings. The Monitoring Team also noted significant improvement with the QDRR process; QDRRs were more complete and demonstrated careful review of all necessary diagnostics, including laboratory studies, EKGs, and bone density studies. Additional refinement of the QDRR process will be required for substantial compliance for Sections N.2 and N.3, and the Monitoring Team recommends that the reviewing pharmacist ensure that the QDRR reviews include: documentation of the indication for prescribed drugs, as well as the indication for prescribed polypharmacy; the pharmacist's agreement, or disagreement with the indication, and dose of the pharmacotherapy, and when clinically necessary offer alternative pharmacotherapy treatment recommendations; assess, and document efficacy of pharmacotherapy; assess and document side effects, as well as known and potential drug interactions; and ensure that the interdisciplinary team and the integrated risk rating form list all potential serious side effects that must be closely monitored by staff. The Monitoring Team continues substantial compliance for Sections N.1, and N.4 through N.8. The Monitoring Team did note that for three out of five examples provided for Section N.5, there was no evidence of enhanced monitoring for increased dosage of a neuroleptic, or when a new order for a neuroleptic was prescribed. The Monitoring Team will continue substantial compliance for Section N.5, and recommends that at subsequent reviews the Facility ensure |

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| | that more frequent side effect monitoring is provided when initiating a new neuroleptic drug or increasing the dose of a neuroleptic drug. The Monitoring Team compliments the Facility and the pharmacy department, for its continued improvements. The following are specific observations, comments and recommendations for Sections N.1 through N.8:<br><br>**Section N.1:** The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.<br><br>**Section N.2:** The Monitoring Team noted significant improvement with completion of the QDRRs. There has been significant improvement with the level of review of diagnostics, and assessment of metabolic syndrome. In all cases, the appropriate medical provider reviewed, signed, and concurred with the pharmacist's recommendations. Substantial compliance, however, will require further enhancement of the QDRR process by ensuring that the pharmacist assesses and documents efficacy, and when necessary, recommends alternative treatments; clearly delineate the indication, and if the indication for medications are appropriate; document potential serious and common side effects; carefully document a review of side effects.<br><br>**Section N.3:** The pharmacy had significantly improved on its review of polypharmacy, stat chemical restraints, usage of benzodiazepines, and anticholinergics, and metabolic syndrome. As documented within the context of Section N.3, of this report, substantial compliance will require that the Facility continue to enhance documentation of risks, and potential risks, associated with the use of polypharmacy, benzodiazepines, anticholinergics, and the risks associated with medications related to metabolic syndrome. Specific to review for stat chemical restraints, the pharmacy department must ensure a comprehensive and clinically appropriate review of the use of stat chemical restraints.<br><br>**Section N.4:** The Monitoring Team determined that the Facility continued to have a process that required medical providers and psychiatrists to review and address clinical concerns raised by the pharmacists, and determined that the Facility remained in substantial compliance with Section N.4.<br><br>**Section N.5:** Although previous substantial compliance was determined in the past, the Monitoring Team noted that for the five examples provided for Section N.5, there were no examples of more frequent monitoring for tardive dyskinesia following the prescription of a new neuroleptic drug, or when there was an increase in the neuroleptic dosage. The Monitoring Team will continue substantial compliance at this time; however, for continued substantial compliance in the future, the Facility is strongly encouraged to ensure more frequent monitoring for emergence of tardive dyskinesia, when clinically necessary. The Monitoring Team did note that the Facility ensured timeliness, and completeness of regularly scheduled MOSES and DISCUS assessments.<br><br>**Section N.6:** The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. |

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| | **Section N.7:** The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.<br><br>**Section N.8:** The Monitoring Team noted continued improvement with the Facility's medication variance process. The process ensured that all relevant departments, including nursing, pharmacy, and medical department were closely monitoring for medication variance, and potential medication variances. Medication variances, and potential medication variances, were stratified by type, severity, living area, department, and staff. Medication variances were tracked and trended, and were thoroughly discussed at the monthly medication variance meetings; when identified, appropriate action plans were developed and followed through to completion. The total number of medication variances reported by the Facility falls well within expected standards of care, when comparing to national averages of long-term care Facilities. The Monitoring Team compliments the pharmacy, nursing, and medical departments for developing, and implementing a sound medication variance process, and determined continued substantial compliance for Section N.8. |

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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. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| N2 | Within six months of the Effective | To assess that the Facility conducts quarterly drug regimen reviews (QDRRs), that are | Noncompliance |

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| | Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values. | consistent with generally acceptable standard of care practice, and that the QDRRs are completed within the Facility's 14 day window for scheduled completion of QDRRs, the Monitoring Team reviewed the following documents:<br>• QDRR schedule for past six months, and pending six months<br>• List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date<br>• Alpha list of individuals who were prescribed a neuroleptic and have diabetes<br>• Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension<br>• Alpha list of individuals who were prescribed a benzodiazepine<br>• Alpha list of all individuals with diagnosis of osteoporosis<br>• Alpha list of all individuals with diagnosis of seizure disorder<br>• The Monitoring Team selected the following examples from the alpha lists (Individuals #703, #90, #666, #248, and #185):<br>o Most recent two QDRRs<br>o Past six months MOSES and DISCUS assessments<br>o Most recent 12 months of lab results<br>o Most recent two EKG reports<br>o Most recent annual physician summary<br>o Most recent psychiatric assessment<br>o Most recent IRRF<br>o Current medication list<br>o Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale<br><br>The following is a summary of the Monitoring Team review of the examples provided for Individuals #703, #90, #666, #248, and #185:<br>• Of the five examples, five out of five (100%) were completed within 14 days of the annual ISP meeting.<br>• The pharmacist assessed Laboratory and other diagnostics, such as EKGs and DEXA scans, in five out of five examples (100%).<br>• Metabolic syndrome was appropriately assessed in five out of the five examples (100%) that required a review for metabolic syndrome.<br>• The QDRR indicated review by the medical provider in five out of five examples (100%).<br>• The QDRR indicated review by the psychiatrist in four out of the four examples (100%) of the QDRRs that required review by the psychiatrist. One example did not include psychotropic medications. | |

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| | | • The completed MOSES and DISCUS were included as part of the assessments for the QDRRs in four out of five (80%) examples. The DISCUS assessment for Individual #90 was not fully completed by the medical provider, and the pharmacist should have identified that during the QDRR review. It is essential for the pharmacist to review the medical provider's completion and diagnosis of the DISCUS assessment, and if the pharmacist does not concur with the medical provider's assessment, a comment on the QDRR should be documented.<br>• The QDRR clearly delineated effectiveness of all drugs prescribed in zero out of five examples (0%). The pharmacist must document efficacy, and appropriateness of all prescribed medications prescribed, and offer alternative recommendations when clinically appropriate.<br>• Of the five examples, there were two instances of polypharmacy, and in zero out of two examples (0%), the pharmacist addressed polypharmacy, and included a specific statement indicating the appropriateness of polypharmacy.<br>• For the one individual treated with benzodiazepines, one out of one (100%) examples indicated a specific assessment for the use of benzodiazepine by the pharmacist that included a statement indicating the clinical appropriateness for continued scheduled administration.<br>• The Monitoring Team noted that the pharmacist did not well document review of side effects, or potential drug interactions for all of the medications prescribed. The Monitoring Team would like to recommend that the pharmacist be more specific when assessing side effects and interactions by documenting a specific comment indicating that the review of the pharmacotherapy profile and assessment of clinical information identified no side effects, or drug interactions.<br><br>Summary:<br>The Monitoring Team noted significant improvement with completion of the QDRRs. There has been noted significant improvement with the level of review of diagnostics, and assessment of metabolic syndrome. In all cases, the appropriate medical provider reviewed, signed, and concurred with the pharmacist's recommendations. Substantial compliance, however, will require further enhancement of the QDRR process by ensuring that the pharmacist assesses and documents efficacy, and when necessary, recommends alternative treatments; clearly delineate the indication, and if the indication for medications are appropriate; and more clearly document a review of side effects, including potential serious and common side effects. Also, the pharmacist should ensure that when reviewing MOSES and DISCUS assessments, that these have been completed by the medical provider. | |
| N3 | Commencing within six months of the Effective Date hereof and with | Provision N.3 requires that the Facility evaluate its process and usage of stat emergency medications, polypharmacy, benzodiazepines, anticholinergics, and metabolic syndrome. | Noncompliance |

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| | 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. | <u>Benzodiazepine usage:</u><br>The Monitoring Team requested the following documents to review the Facility's review of benzodiazepine use:<br>• Alpha list of all individuals on a benzodiazepine<br>• Data analysis and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use<br>• For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication:<br>o Most recent two QDRRs<br>o Most recent IRRF<br>o Current medication list<br>o Most recent psychiatric assessment<br>o Most recent annual medical assessment<br><br><u>Assessment of Benzodiazepine usage</u><br>Based on review of the clinical documents, per the document request, the Monitoring Team made the following determination, for the five examples provided by the Facility (Individuals #703, #236, #305, #33, and #483):<br>• In four out of five cases (80%), the QDRR documented the use and indication for the use of the benzodiazepine. The QDRR for individual #236 did not document the indication.<br>• In one out of five cases (20%), the QDRR documented risks associated with the use of the benzodiazepine; however, review of associated IRRFs indicated that zero out of five examples (0%) commented on risks associated with benzodiazepine. The Monitoring Team suggests it is important to comment on specific risks associated with the use of benzodiazepines. Paradoxical agitation, cognitive decline, and fall risk are all important risks that should be clearly understood by the IDT, delineated on the QDRR, and considered in developing the IRRF.<br>• In one out of five examples (20%), the QDRR documented efficacy or lack of efficacy for the benzodiazepine. The reviewing pharmacist must determine, by review of clinical documentation, including review of side effects and behavioral data, if the benzodiazepine is efficacious or not efficacious, and make appropriate recommendations when necessary<br>• In zero out of five examples (0%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. | |

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| | | The Facility should enhance its review of benzodiazepine usage within the context of the QDRR process. The reviewing pharmacist should independently verify efficacy, and make appropriate recommendations to continue the medication, discontinue the medication, or indicate the need for a dose change. It is essential that the pharmacist ensure that the IDT is well aware of potential risks and benefits of the use of benzodiazepines, and these risks should be well delineated in the annual ISP and IRRF.<br><br><u>Review of Anticholinergic Usage</u><br>To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents:<br>• Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties<br>• Data, graphs, and data analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties<br>• Alpha list of individuals who are prescribed anticholinergic drugs<br>• For the first five individuals on the list of individuals prescribed anticholinergic drugs (Individuals #11, #707, #741, #533, and #472)<br>o Most recent two QDRRs<br>o Current medical list<br>o Most recent medical, and psychiatric annual reviews<br>o Most recent MOSES and DISCUS assessments<br><br>The following is a summary of the pharmacy's clinical review of anticholinergic medications during the QDRR process for Individuals #11, #707, #741, #533, and #472:<br>• In two out of five examples (40%) the QDRR documented the indication for the use of all anticholinergics prescribed. The Facility did indicate the indication for the Benztropine; however, the Facility must identify, and assess for the use of all drugs with anticholinergic properties.<br>• In five out of five cases (100%), the QDRR documented risks associated with the use of anticholinergics. The QDRR for Individual #97 indicated that close monitoring was required because the individual was prescribed "haloperidol, Cogentin, and quetiapine, and have additive anticholinergic effects".<br>• In five out of five examples (100%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics.<br><br>Summary:<br>The Pharmacist documented a comprehensive review of the use of medications usage associated with anticholinergic properties in 100% of the five examples reviewed.<br><br><u>Review of polypharmacy usage</u>: | |

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| | | To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents:<br>• Psychiatric medication oversight committee (POMC) meeting minutes for 10/17/2013<br>• List of all individuals on polypharmacy<br>• For the first five individuals on the list of polypharmacy (Individuals #28, #605, #250, #604, and #165):<br>o Most recent two QDRRs<br>o Most recent psychiatric assessment<br>o Current medication list<br>o Most recent ISP, or related document the use of polypharmacy<br><br>The following is a summary of the documents reviewed for polypharmacy:<br>• In five out of five examples (100%) the QDRR documented the indication for the use of each drug associated with polypharmacy.<br>• In zero of five examples (0%), the QDRR documented serious risks for the use the polypharmacy combination. The QDRR did not list specific potential side effects, and other potential consequences, such as drug-drug interactions, that should be closely monitored. Within the context of a developmental center, IDT members must be made well aware of all known and possible serious risks that should be closely monitored, associated with prescribed medications, by ensuring that relevant risks for prescribed medications are documented on the QDRR and on the IRRF. The QDRR should provide other IDT members an understanding of the risks associated with the prescribed polypharmacy, and that was not clearly delineated.<br>• In zero out of five examples (0%), the current IRRF assessment documented risks associated with polypharmacy.<br>• In one out of five cases (20%), the QDRR documented the use of polypharmacy was clinically justifiable, or provided recommendations for alternative dosage or treatment. The QDRR must document recommendations for each medication associated with polypharmacy.<br>• In zero out of five cases (0%), the pharmacist documented the efficacy, or lack of efficacy, for the use of polypharmacy. The QDRR should document the efficacy, or lack of efficacy for the polypharmacy.<br><br>The QDRRs did identify and list the clinically appropriate indication for the use of polypharmacy; however, there was no consistent documentation of common and serious side effects, assessment of polypharmacy-associated side effects, documentation of clinical efficacy of polypharmacy, and recommendations to help reduce polypharmacy when clinically appropriate. The IRRF did not document common and serious side | |

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| | | effects associated with polypharmacy.<br><br><u>Assessment of Metabolic Syndrome Monitoring:</u><br>The Monitoring Team selected the first five and last five individuals on a list of all individuals who are on a neuroleptic and had a diagnosis of diabetes or hypertension, and reviewed the following documents to assess the Facility's monitoring of metabolic syndrome. Nine of the ten requested examples were provided (individuals #.<br>• Most recent QDRR<br>• Most recent IRRF<br>• Current medication list<br>• Most recent six months laboratory data<br>• Most recent annual medical assessment<br>• Most recent psychiatric assessment<br>• Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome<br><br>The Facility reported a total of 72 individuals being assessed as having the diagnosis of metabolic syndrome; 35 of the 72 (49%) of those diagnosed with metabolic syndrome were prescribed an antipsychotic drug.<br><br>The following is a summary of the documents reviewed for metabolic syndrome, for the seven examples provided (Individuals #490, #599, #606, #397, and #791):<br>• Five of five QDRRs (100%) indicated specific review for metabolic syndrome on the QDRR report.<br>• Five out of five QDRRs (100%) assessed clinically appropriate risk factors to evaluate for metabolic syndrome.<br>• The associated IRRF documented a specific risk assessment for metabolic syndrome in one out of five examples (20%). The IRRF must document associated risks of medications that are known to cause metabolic syndrome, especially when an individual has diabetes, hypertension and hyperlipidemia. For example, Individual #791 has a known diagnosis of hypertension, metabolic syndrome, and significant risks for coronary artery disease, and the IRRF did not discuss risks of metabolic syndrome and associated manifestations secondary to being on a neuroleptic. Individual #606 has a diagnosis of diabetes and hypertension, and specific risks associated with metabolic syndrome were not documented on the IRRF.<br>• The Pharmacist discussed the risk versus benefit for either continuing or discontinuing the medication associated with metabolic risk in zero out of five examples (0%). | |

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| | | Summary: The Facility had significantly improved on the identification and reporting of metabolic syndrome, and of risk factors associated with metabolic syndrome. It is essential, however, that the pharmacist ensure that all associated risks are communicated on the IRRF, and that all medications, and associated risks and benefits of the medications as related to metabolic syndrome, be well documented, and included as part of the IRRF assessment.<br><br><u>Stat chemical restraint usage:</u><br>The Monitoring Team requested a list of all stat chemical restraint data, data analysis, summaries, and committee meeting minutes for the use of stat chemical restraints that were administered during the reporting period, and for the first ten individuals who were administered a state chemical restraint during the reporting period:<br>• Copy of the Facility's Face-to-Face debriefing report, or other documentation indicating a review of the usage of stat chemical restraint by the pharmacist, and the psychiatrist<br>The Monitoring Team, was provided the following documentation:<br>• List of all stat chemical restraint data, data analysis, summaries, for the use of stat chemical restraints during the reporting period<br>• Pharmacy and Therapeutics Committee (P&TC) meeting minutes, 9/24/2013<br>• Post chemical restraint clinical review form, undated, no identifying information list.<br>• QDRR for Individual #119, dated 10/10/2013<br><br>The Facility reported one stat chemical restraint provided during the reporting period (Individual #119). The associated P&TC meeting minutes documented a clinically meaningful review of the restraint. Following is a review of the post chemical restraint clinical review form; note, however, the review form did not document the Individual's name, or other identifying information, and was not dated:<br>• Pharmacist's review:<br>o In one out of one example (100%), the pharmacist documented a review of scheduled psychotropic medications, and if the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint.<br>o In one out of one example (100%), the pharmacist documented if side effects occurred following the stat chemical restraint.<br>o In one out of one example (100%), the pharmacist documented if the indication for the stat chemical restraint was appropriate.<br>o In one out of one example (100%), the pharmacist documented if drug and dose used for the stat chemical restraint were clinically appropriate.<br>o In one out of one example (100%), the pharmacist documented if | |

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| | | currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint.<br>• Psychiatrist's review:<br>o In one out of one example (100%), the psychiatrist documented the clinical rationale for the use of the stat chemical restraint, and if the stat chemical restraint was appropriate or not appropriate.<br>o In one out of one example (100%), the psychiatrist documented if side effects occurred following the stat chemical restraint.<br>o In 0 out of one example (0%), the psychiatrist documented if drug and dose used for the stat chemical restraint were clinically appropriate.<br>o In 0 out of one example (0%), the psychiatrist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint.<br>o In one out of one example (100%), the psychiatrist documented a review of scheduled psychotropic medications, and if the scheduled medication dose, formula, or schedule should be changed to help minimize the need for stat chemical restraint.<br>o In one out of one example (100%), the psychiatrist documented a review of the behavior intervention plan, and indicated if the plan was clinically appropriate or required enhancement to help reduce the need for stat chemical restraint.<br><br>The Facility ensures that the pharmacist and psychiatrist review and ensure that stat chemical restraints were clinically appropriate, and within standard of care practice. The Facility reviews the use of stat chemical restraints in the context of the P&TC.<br><br><u>Systems review for anticholinergics, benzodiazepines, and polypharmacy</u><br>Systems review for medication with anticholinergic properties: The Facility conducts a systems review of anticholinergic medication usage each quarter at its P&TC committee meeting; however, the Facility provided P&TC committee minutes and a summary of anticholinergic usage for the 7/23/2013 P&TC meeting, and not for the most recent meeting for quarters three and four. The minutes and anticholinergic summary of the P&TC meeting indicated 310 out of 489 individuals (64%) were prescribed medications with associated anticholinergic properties, which was slightly increased from the previous quarter (63%). The summary indicated that the increase was secondary to a census drop of 10 individuals. The Facility provides an effective review of anticholinergic usage, and reports on both psychotropic, and non-psychotropic anticholinergic usage; and indicates polypharmacy-related issues, such as the number of Individuals prescribed intraclass agents, and the number of individuals who are prescribed one, two, three, or four medications with anticholinergic properties. The | |

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| | | Monitoring Team compliments the pharmacy department for its extensive review of the systems usage of anticholinergic medications.<br><br>Systems review for benzodiazepine usage. The Facility provided the 7/23/2013 P&TC committee meeting minutes, as well as benzodiazepine data tracking and analysis for July 2013 and October 2013. The documents provided demonstrated evidence of a comprehensive systems review of the Facility's usage of benzodiazepines at the Facility. The pharmacy tracks and trends the total number of individuals administered scheduled benzodiazepines, and includes a breakdown of the type of indication, such as psychiatric, seizure disorder, insomnia, and other neurologic conditions, including tremors and spasticity. Within the October 2013 data tracking report, and summary, the Facility reported a total of 39 individuals being administered a scheduled benzodiazepine to address:<br>Tremor/spasticity 5<br>Seizures 7<br>Psychiatric 27<br><br>The summary included on the October 2013 tracking report, and the 7/23/2013 P&TC meeting minutes, documented a review of the usage, and trends analysis since December 2011. The Facility provided a medication order trends report for benzodiazepines, dated December 2013; however, because the P&TC had yet to complete its fourth quarter review for 2013, P&TC minutes did not document a review of this most recent data. The December 2013 medication order trends report for benzodiazepines did indicate a continued increase in the use of benzodiazepines, indicating 41 individuals currently prescribed benzodiazepines; the associated analysis indicated that the Facility had two new admissions to the Facility resulted in the increased number of individuals being prescribed benzodiazepines. The Monitoring Team determined that the pharmacy department conducts appropriate systems review of benzodiazepines usage at the Facility.<br><br>Systems review for polypharmacy usage: The Facility continues to conduct monthly polypharmacy meetings, and reports are generated for the quarterly P&TC meetings. The Pharmacy's review of polypharmacy continues to be comprehensive and clinically meaningful. The Pharmacy not only reviews psychiatric polypharmacy but polypharmacy associated with anticonvulsant therapy, and comorbid psychiatric and neurological polypharmacy.<br><br>Specific to the December polypharmacy meeting minutes, the Facility discussed the usage of antiepileptic drugs (AEDs), and indicated the following:<br>Total number on AEDs 268<br>On 2 AEDs 75 | |

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| | | On 3 AEDs 49<br>On 4 AEDs 6<br>On 5 AEDs 2<br>On 6 AEDs 1<br>Number individuals on 3 or more AEDs 63<br><br>Number of individuals on older AEDs:<br>Number on Phenobarbital 33<br>Number on Dilantin 61<br>Number on Mysoline 10<br>Number on Felbamate 6<br>Total on older AEDs 110<br><br>The December 2013 polypharmacy meeting minutes summarized the AEDs, AED polypharmacy, and the usage of older AEDs, such as phenobarbital, Dilantin, Mysoline, and Felbamate. The minutes indicated an increased use of older AEDs by five individual during the reporting period, and indicated three individuals were recently transferred to the Facility with the medication prescribed prior to admission. The summary of AED usage, and associated polypharmacy, and the use of older AEDs, was clearly described, and informed to the medical providers and the consulting neurologist. The pharmacy department requested that medical providers carefully review QDRRs, and address concerns noted by the pharmacist, with the consulting neurologist.<br><br>Polypharmacy trends data and minutes of the December 2013 polypharmacy meeting indicated that polypharmacy trends for both neurological and psychiatric indications had increased during the reporting period. Psychotropic polypharmacy was up from 154 individuals on polypharmacy to 162 individuals; and neurological polypharmacy was up from 116 to 133 individuals on polypharmacy for a neurological indication. The polypharmacy committee informed providers and the medical director of the increase in polypharmacy use. The psy-med committee will review the December data, and determine if the polypharmacy is appropriate or not appropriate. Furthermore, the polypharmacy committee reviews all individuals who are provided polypharmacy every six months, and makes specific recommendations for the medical provider to consider.<br><br>Conclusion:<br>The pharmacy has significantly improved on its review of polypharmacy, stat chemical restraints, usage of benzodiazepines, and anticholinergics, and metabolic syndrome. As documented within the context of Section N.3, of this report, substantial compliance will require that the Facility continue to enhance documentation of risks and potential risks associated with the use of polypharmacy, benzodiazepines, anticholinergics, and the risks associated with medications related to metabolic syndrome. Specific to review for | |

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| | | stat chemical restraints, the pharmacy department ensure a comprehensive and clinically appropriate review of the use of stat chemical restraints. | |
| N4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed. | Because the Facility had been in substantial compliance with Section N.4, on two previous Compliance reviews, the Monitoring Team performed a limited review of Section N.4 at this review, and relied on documents from Section N.2, of this report.<br><br>The following is a summary of the Monitoring Team's review of completed QDRRs, to assess if medical providers reviewed, and appropriately indicated follow-up to pharmacist's recommendations, for the following examples:<br>• The QDRR indicated review by the medical provider in five out of five examples (100%).<br>• The medical provider indicated agreement with the pharmacist's recommendations in five out of five examples (100%).<br>• The QDRR indicated review by the psychiatrist in four out of the four examples (100%) of the QDRRs that required review by the psychiatrist. One example did not include psychotropic medications.<br>• The Psychiatrist indicated agreement with the pharmacist's recommendations in the four, out of four (100%) examples that required review by the psychiatrist.<br><br>Summary:<br>The Monitoring Team determined that the Facility continued to have a process that required medical providers and psychiatrists to review, and address clinical concerns raised by the pharmacists, and determined that the Facility remained in substantial compliance with Section N.4. | Substantial Compliance |
| N5 | Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia. | To assess the Facility's ability to ensure clinically appropriate drug monitoring of tardive dyskinesia, the Monitoring Team reviewed regularly scheduled MOSES and DISCUS assessments following changes in neuroleptic medications. In addition, findings from Section J12 were used to determine compliance.<br><br>For Section N.3, of this report, the Monitoring Team reviewed a total of 12 MOSES and 10 DISCUS assessments provided for Individuals #703, #90, #666, #248, and #185:<br>• In 12 out of 12 MOSES assessments (100%) there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool.<br>• In 9 out of 10 DISCUS assessments (90%) there was evidence that the prescriber signed, dated, and completed the physician component of the assessment tool.<br><br>From a list of all individuals who had either a new neuroleptic medication prescribed, or | Substantial Compliance |

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| | | who had an increase in the dose of a prescribed neuroleptic during the reporting period, the Monitoring Team reviewed all MOSES and DISCUS assessments completed for the five individuals on the list. The following is a summary of the Monitoring Team's review of the MOSES and DISCUS assessments provided for review (Individuals #666, #251, #800, #629, and #21):<br>• Of the 12 MOSES and DISCUS assessments reviewed, 12 out of 12 examples (100%) were signed and fully completed by the medical provider.<br>• Increases in neuroleptic doses had occurred for four individuals. More frequent side effect monitoring was provided when clinically necessary in two out of four examples (50%).<br>o Individuals #800, and #629 had increases in their dose of neuroleptic, and both were provided enhanced side effect monitoring by MOSES and DISCUS.<br>o Individual #251: An increase in the scheduled neuroleptic dose occurred on 11/19/213, and there was no evidence of increased monitoring by MOSES and DISCUS following the increased dose.<br>o Individual #21: The scheduled neuroleptic dose was increased on 9/4/2013, and follow-up MOSES and DISCUS were dated 11/29/2013 and they were documented as three month follow-up; hence, additional monitoring by MOSES and DISCUS was not provided,\ as clinically indicated.<br><br>Summary:<br>Although previous substantial compliance was determined in the past, the Monitoring Team noted that for the four examples provided for Section N.5 or increase in neuroleptic dosage, more frequent monitoring for tardive dyskinesia was not done consistently. The Monitoring Team will continue to find substantial compliance at this time; however, for continued substantial compliance in the future, the Facility is strongly encouraged to ensure more frequent monitoring for emergence of tardive dyskinesia, when clinically necessary. The Monitoring Team did note that the Facility ensured timeliness, and completeness of regularly scheduled MOSES and DISCUS assessments. | |
| N6 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions. | The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |

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| 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 parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for three consecutive reviews. The substantial compliance finding from the last review stands. | Substantial Compliance |
| N8 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances. | The Monitoring Team assessed the Facility's medication variance process by reviewing:<br>• All data, trends analysis and last six months committee meeting minutes specific to the Facility's system review of all medication variances that occurred during the reporting period<br>• List of all medication variances that occurred during the reporting period<br>• Data, data analysis, and all related committee meeting minutes specific to the review, analysis, and improvements necessary for drug reconciliation issues (such as drug overusages)<br>• For the first and then every second individual on the list of all medication variances, for a total of ten examples, that occurred during the reporting period (Individuals #367, #292, #425, #292, #581, #75, #667, #222, #136, and #212)<br>o Copy of medication variance reporting forms<br>o All physician IPNs associated with the medication variance<br>o All nursing IPNs associated with the medication variance (initial assessment, and through the monitoring period for the medication variance)<br>o All pharmacy documentation, and communication related to the medication variance<br>o All IDT minutes specific to the medication variance<br><br>In addition, information gained by Section M.6, of this report was used to determine compliance for this, and the reader is referred to Section M.6, of this report for additional insight into the Facility's medication variance process.<br><br><u>Review of the medication variance report forms</u> | Substantial Compliance |

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| | | The Monitoring Team reviewed completed medication variance report forms for the first and then every second individual on the list of all medication variances, for a total of ten examples, that occurred during the reporting period (Individuals #367, #292, #425, #292, #581, #75, #667, #222, #136, and #212), which indicated the following:<br>• 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.<br>• The department supervisor documented appropriate corrective action in ten out of ten (100%) examples.<br>• The pharmacy department reviewed and commented on ten out of ten (100%) examples.<br>• Medication variances were incorporated into the medication variance database, and analysis was presented to the medication variance committee for review in ten out of ten (100%) examples.<br><br><u>Review of the 12/18/2013, and 1/15/2014 medication variance meeting minutes</u><br>Review indicated that the Facility continued to track, and trend all medication variance each month by:<br>• Total variances<br>• Severity of variances<br>• Department responsible for the variance<br>• Staff member responsible for the variance<br>• Living area responsible for the variance<br><br>Review of medication variance committee meeting minutes revealed the following:<br>• The 12/18/2013, and 1/15/2014 medication variance meeting minutes commented on specific systems issues, and specific staffing issues related to the medication variance reported during the previous month.<br>• The 12/18/2013, and 1/15/2014 medication variance meeting minutes outlined action plans for all identified deficiencies related to systems issues associated with medication variances and indicated who was responsible for the action plan, due date for the action plan, and date when the action plan was completed<br><br>The Monitoring Team attended a medical provider's meeting on 1/16/2014. During the meeting there was a detailed review of medication variances that occurred during the quarter, that were associated with medical provider variances.<br><br><u>New and/or Revised Medication Administration Policies and Procedures:</u><br>DSSLC Policy Medication Variance Tracking and Procedures, Pharmacy Policy – 27.1, Revised: 11/10/13 established the process required for medication variance procedures. | |

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Review of the Facility's medication variance practice, indicates that they are following the revised DSSLC medication variance tracking and procedures policy.

Medication Variance Reports:
The Facility continued to have a comprehensive Medication Variance Database for reporting medication variance data. Medication Variance data included Nursing, Medical, Pharmacy, and Dental Departments. 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 July 2013 through December 2013 that had been aggregated, analyzed, and trended, along with remedial actions taken to mitigate medication variances and storage issues.

The chart below shows the total number of medication variances by severity index, reported July 2013 through December 2013:

| Severity Index | Unidentified Other | A | B | C | D | E | F | G | H | I | Monthly Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| July | 1 | 125 | 2 | 77 | 1 | 0 | 0 | 0 | 0 | 0 | 206 |
| August | 1 | 132 | 4 | 59 | 1 | 0 | 0 | 0 | 0 | 0 | 197 |
| September | 0 | 152 | 0 | 77 | 0 | 0 | 0 | 0 | 0 | 0 | 229 |
| October | 1 | 115 | 5 | 61 | 5 | 0 | 0 | 0 | 0 | 0 | 187 |
| November | 0 | 90 | 2 | 42 | 0 | 0 | 0 | 0 | 0 | 0 | 134 |
| December | 0 | 88 | 5 | 42 | 2 | 0 | 0 | 0 | 0 | 0 | 137 |
| Total | 3 | 702 | 18 | 358 | 9 | 0 | 0 | 0 | 0 | 0 | 1090 |

The charts below shows the total number of medication variances by department, reported July 2013 through December 2013:

| Month | Unidentified | Medical | Nursing | Pharmacy | Dental | Other | Total |
|---|---|---|---|---|---|---|---|
| July | 1 | 31 | 83 | 91 | 0 | 0 | 206 |
| August | 1 | 35 | 80 | 81 | 0 | 0 | 197 |
| September | 1 | 63 | 97 | 68 | 0 | 0 | 229 |
| October | 1 | 51 | 84 | 51 | 0 | 0 | 187 |
| November | 0 | 33 | 49 | 52 | 0 | 0 | 134 |
| December | 0 | 30 | 48 | 59 | 0 | 0 | 137 |

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| Total | 4 | 243 | 441 | 402 | 0 | 0 | 1090 |

Summary:
The Monitoring Team noted continued improvement with the Facility's medication variance process. The process ensures that all relevant departments, including nursing, pharmacy, and medical department were closely monitoring for medication variance, and potential medication variances. Medication variances and potential medication variances were stratified by type, severity, living area, department, and staff. Medication variances were tracked, trended, and thoroughly discussed at the monthly medication variance meetings; and when identified, appropriate action plans are developed and followed through to completion. The total number of medication variances reported by the Facility falls well within expectable standards of care, when comparing to national averages of long-term care Facilities. The Monitoring Team compliments the pharmacy, nursing, and medical departments for developing, and implementing a sound medication variance process, and determined continued substantial compliance for Section N.8.

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:**<br>1. DSSLC Self Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. Presentation Book for Section I, Section O, and Section P<br>4. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 10/4/13)<br>5. DSSLC Policy CC-04 Physical and Nutritional Management Committee (10/1/2013)<br>6. DSSLC PNMT Process Flow Chart (10/17/13)<br>7. Universal Monitoring Plan rev: 3/15/13<br>8. Record reviews:<br>a. Sample O.1: Individuals #170, #187, #209, #211, #243, #305, #392, #402, #414, #463, #499, and #689<br>b. Sample O.2: Individuals #170, #305, #499, #581, and #689<br>c. Sample O.3: Individuals #170, #187, #211, #243, #252, #305, #392, and #499<br>9. A list of all therapy and/or clinical staff –occupational therapists (OT), physical therapists (PT), speech-language pathologists (SLP), dietitians (RD), assistive technology staff (AT), and Physical and Nutritional Management team (PNMT) members, including credentials<br>10. A list of continuing education sessions or activities participated in by PNMT members since last review (7/2013)<br>11. Minutes, including documentation of attendance, for the PNMT and Physical and Nutritional Management Committee (PNMC) meetings for the past 6 months<br>12. Individual PNMT reports as available for individuals reviewed above<br>13. A list of PNM assessments and updates completed in the last quarter<br>14. Individual Support Plans (ISPs) for all sample individuals<br>15. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals<br>16. Tools used to monitor implementation of PNM procedures and plans<br>17. A list of individuals for whom PNM monitoring tools were completed in the last quarter<br>18. Tools utilized for validation of PNM monitoring<br>19. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans<br>20. PNMP template and any instructions for use of template<br>21. PNM spreadsheets generated by the Facility<br>22. Lists of individuals:<br>a. On modified diets/thickened liquids;<br>b. With BMI equal to greater than 30;<br>c. With BMI equal to less than 20;<br>d. Since October 2012, who have had unplanned weight loss of 10% or greater over six (6) months;<br>e. During the past six months, have had a choking incident; |

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| | f. During the past six months, have had a pneumonia incident;<br>g. During the past six months, have had skin breakdown;<br>h. During the past six months, have had a fall;<br>i. During the past six months, have had a fecal impaction;<br>j. Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.);<br>k. With poor oral hygiene; and<br>l. Who receive nutrition through non-oral methods<br>23. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review<br>24. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials<br>25. Tools and checklists used to provide competency-based training addressing:<br>a. Foundational skills in PNM; and<br>b. Individual PNM and Dining Plans<br>26. Physical and Nutritional Management Related Training Data<br>**People Interviewed:**<br>1. Paula Horn PT- Director of Habilitation Therapies (HT)<br>2. Becky Nurre CCC-SLP Speech Director<br>3. Eight DCPs (Cedar Falls, Eastfield, Timberhill and Garden Ridge)<br>**Meeting Attended/Observations:**<br>1. Physical and Nutritional Management Team (PNMT) 1/14/14<br>2. Physical and Nutritional Management Committee (PNMC) 1/16/14<br>3. Mealtimes and Transitions- Garden Ridge, Cedar Falls, Timberhill, and Eastfield |
| | **Facility Self-Assessment:**<br>DSSLC's Self-Assessment, updated 12/27/13, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was not in compliance with Sections O.2 through O.8 and in substantial compliance with Section O.1 This was not consistent with the Monitoring Team's findings of noncompliance with Section O.1 and the Monitoring Team's finding of compliance with Section O.3.. Section O.1 was found to be in compliance during the July 2013 review but based upon the findings of an inappropriately staffed PNMT, the finding of compliance was withdrawn. Section O.3 was found to be in compliance as the PNMPs reviewed were determined to be comprehensive and provide the needed guidance to staff to mitigate risk.<br><br>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 remained a strong point of the facility self-assessment process. Indicators used to assess specific areas (e.g., assessments) were clearly identified and measurable. |

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| | Overall, the Action Plans dated 12/5/13 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.<br><br>The Self-Assessment did not state the following staff/positions that 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.<br><br>The Action 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.<br><br>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:**<br>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 when not referred to the PNMT. These individuals were primarily reviewed by the IDT. PNMPs were noted to have become more comprehensive and provided staff with detailed strategies to mitigate associated PNM risks.<br><br>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 training prior to working with those individuals who were at an increased risk.<br><br>**Provision O.1:** This provision was determined to not in compliance. An adequate Physical and Nutritional Management Team (PNMT) was no longer in place as participation by the core physical therapist (PT) and the core dietitian was not consistent. Failure to have consistent participation results in non-interdisciplinary approach to PNM care. The Facility was using caseload PTs to attend in place of the core PT since September 2003 but their level of participation and presence in PNMT meetings was below thresholds needed to be considered a standing core member of the PNMT.<br><br>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. |

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| | 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 evaluation process for individuals who are enterally fed, 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. Although collaboration with Dental was not noted to be part of the PNM policy, there was evidence of collaboration as it related to desensitization and the determination of suction tooth brushing.<br><br>**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 IDT meeting.<br><br>**Provision O.3:** This provision was determined to be in substantial compliance. PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers. Issues regarding consistency of the PNMPs across the various locations (i.e., MARs and "Me" books) appeared to have been resolved based upon the drawn sample.<br><br>**Provision O.4:** This provision was determined to be not in compliance. Staff was not consistently observed implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were not consistently provided with safe dining or positioning strategies.<br><br>**Provision O.5:** This provision was determined to be not in compliance. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the necessary training prior to working with the individual.<br><br>**Provision O.6:** This provision was determined to be not in compliance. All areas in which difficulties are likely to be provoked were not receiving adequate monitoring. Another issue noted was that no monitoring occurred on 3rd shift. The risks of PNM issues are not limited to first and second shift and, while it is not expected that third shift will have the same frequency of monitors, the need for some level of formal monitoring exists.<br><br>**Provision O.7:** This provision was determined to be not in compliance. There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized 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 that referral criteria and PNMT thresholds were integrated as part of the Integrated Health Care Plans (IHCPs). Additionally, indicators were not regularly reviewed by the IDT in an effort to determine if changes were needed to the PNMP or overall PNM plan of care. |

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| | **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 professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional | The following samples were utilized for Section O:<br><br>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.<br><br>Sample O.2 consisted of five individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months.<br><br>Sample O.3 consisted of eight individuals at DSSLC who received enteral nutrition. Some of these individuals might have been included in one of the other samples.<br><br>DSSLC continued to utilize both a Physical and Nutritional Management Team (PNMT) and 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 had been developed. There was evidence that data were collected and the PNMC was reviewing this data to better identify system issues.<br><br>This provision was determined to be in noncompliance. A Physical and Nutritional Management Team (PNMT) no longer existed that consisted of the appropriate members. The PNMT was missing a core physical therapist (PT) and the registered dietitian (RD) did not consistently attend the PNMT Core Meetings. This lack of consistent attendance by the RD was an issue identified as part of the last compliance review and was not rectified by DSSLC. The lack of a consistent presence of PT at the PNMT was a new finding and as stated, represented a significant decline since the last visit. The Facility was using caseload PTs to attend in place of the core PT since September 2003 but their | Noncompliance |

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| | 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. | level of participation and presence in PNMT meetings was below thresholds needed to be considered a standing core member of the PNMT; there were not caseload PTs present at the core PNMT meetings on a consistent basis, with attendance primarily occurring at joint PNMT/IDT meetings but not at core meetings. The Facility reported that a designated time for core PNMT meetings will now occur as a result of the compliance visit.<br><br>A localized PNMT policy (DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy-rev 10/4/13) existed 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, and the criterion used to guide the PNMT in establishing the level of PNMT support, were also included in the policy.<br><br>It should be noted that areas regarding a comprehensive PNMP, and proper development and review by the IDT, are included in Provisions O.2 and O.3 and therefore were not included in this provision.<br><br>**PNM Policy and Role of the PNMT:**<br>The Facility did have evidence of a comprehensive PNM Policy. The only area noted missing from the PNM policy was information regarding collaboration with Dental. While this was not addressed in policy, it was noted to be in practice and occurring on a consistent basis. The PNM policy along with the PNMC policy and PNMT flow process contained the following components:<br>• Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP");<br>▪ The annual review process of an individual's PNMP as part of the individual's ISP;<br>▪ 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;<br>▪ The roles and responsibilities of the PNMT;<br>▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant);<br>▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs;<br>▪ Requirements for continuing education for PNMT members;<br>▪ Referral process and entrance criteria for the PNMT;<br>▪ Discharge criteria from the PNMT;<br>▪ Assessment process; | |

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| | | ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans;<br>▪ The PNMT consultation process with the IDT;<br>▪ Method for establishing triggers/thresholds;<br>▪ Evaluation process for individuals who are enterally fed;<br>▪ PNMT follow-up;<br>▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including:<br>o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk,<br>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),<br>o Identification of monitors and their roles and responsibilities,<br>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,<br>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<br>o Frequency of monitoring to be provided to all levels of risk.<br>▪ A system of effectiveness monitoring; and<br>▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system included:<br>o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes;<br>o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed;<br>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):<br>o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan).<br>o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and<br>o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the | |

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| | | resolution of systemic issues.<br><br>Missing from the policies was:<br>▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia.<br><br>As mentioned previously, while this component was missing from the policies and procedures reviewed, there was evidence that regular communication occurred between Dental and the PNMT.<br><br>**Core PNMT Membership:**<br>Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did not have the appropriate discipline membership as defined in the Settlement Agreement. DSSLC had identified the Registered Nurse (RN), Registered Dietitian (RD), Physical Therapist (PT), Speech Language Pathologist (SLP), and Occupational Therapist (OT) as standing core members with back-up members identified for RD, RN, OT, and PT. Although backups were identified, presence of the PT and RD were less than 60% and 50% respectively.<br><br>**Consultation with Medical Providers and IDT Members**<br>For five of five individuals in Sample O.2 (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities.<br><br>For five of five 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 members of the individuals discussed were consistently involved in the meetings.<br><br>**Qualifications of PNMT Members**<br>Six of six core PNMT members (100%) were licensed to practice in the state of Texas and six of six PNMT Members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines.<br><br>**Qualifications of Back-Up PNMT Members**<br>Ten of ten back-up PNMT members (100%) were licensed to practice in the state of Texas and ten of ten back-up PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. | |

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| | | **Continuing Education**<br>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.<br><br>Sixteen of 16 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:<br>• Strength Based approach to Dementia Rehabilitation<br>• Pneumonia<br>• Surgical Intervention for Dysphagia<br>• GI Issues, Constipation, and Sepsis<br>• Oral Motor Assessment<br>• Return to Oral Eating<br><br>**PNMT Meetings**<br>From 6/1/13 to 11/30/13, of the 26 weeks, the PNMT met 26 of 26 weeks weeks at a minimum of once weekly (100%) with some weeks meeting more than once.<br><br>Based upon review of the PNMT signature sheets, attendance for the PNMT meetings were as follows:<br>• The OT attended 58 of 65 (89%) PNMT meetings<br>• The SLP attended 60 of 65 (92%) PNMT meetings<br>• The RN attended 60 of 65 (92%) PNMT meetings<br>• The RD attended 36 of 65 (47%) PNMT meetings<br>• The PT attended 32 of 35 (91%) PNMT meetings prior to becoming the HT Director (6/13 to 8/13) and only four of 30 (13%) after becoming HT director.<br><br>The above percentages represent a substantial decline in attendance by the PT and RD. Although a number of PTs and RDs were identified by DSSLC as being backups, there was no evidence that the backups were consistently present at the PNMT meetings.<br><br>All core members of the PNMT were present for at least 80% of the meetings with the exception of the RD and PT. This lack of consistent attendance by the RD was an issue identified as part of the last compliance review and has not appeared to have been rectified by DSSLC. The lack of a consistent presence of PT at the PNMT was a new finding and as stated, represented a significant decline since the last visit.<br><br>In order to regain compliance with this provision, DSSLC must identify a replacement PT | |

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| | | core member and ensure both the PT and RD attends the PNMT meetings on a consistent basis. Per the HT director, beginning the week of 1/13/14, the PNMT will begin to have a caseload PT present at the meeting until a core member is identified. One of the reasons identified by the HT Director of the lack of participation by the RD was that at the time of the review, the RD's caseloads were averaging 160 individuals. Due to the high ratio of clinician to individual ratio, it is recommended that DSSLC consider adding additional Dietary staff to assist in meeting the needs of the individuals.<br><br>Thirteen of the 13 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.<br><br>**Physical and Nutritional Management Committee**<br>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:<br>1. Identify systemic PNM and clinical issues through:<br>a. Review of facility data related to PNM<br>b. Reports from PNMT, IMRT, QA/QI, Medical, Dental, and nursing committees<br>2. Develop action plans to address systemic PNM and clinical issues<br>3. Monitor/review data to determine effectiveness of action plans<br><br>Per review of the PNMC minutes from 6/1/13 to 11/30/13 there was evidence that the PNMC reviewed systemic issues at DSSLC. Among the issues discussed included:<br>• Fall prevention<br>• Occurrence of pneumonia<br>• Other issues related to dysphagia, oral hygiene, mobility and skin integrity<br><br>Members of the PNMC included:<br>• Facility Director-Nancy Condon<br>• Assistant Director of Programs-Dora Tillis<br>• Medical Director-Dr. Stephen Kubala<br>• Habilitation Therapies Director-Paula Horn<br>• Chief Nurse Executive-Delia Schilder<br>• Nurse Operations Officer-Sherri Courtney<br>• RN Case Manager Supervisor-Diane Porter<br>• PNMT Occupational Therapist-Jean Myketlyn<br>• QA Director-Lori Powell | |

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| | | PNMC attendance was reviewed from 6/1/13 to 11/30/13 and found attendance was satisfactory as all members of the PNMC had an attendance record of greater than 85%.<br><br>The PNMC in collaboration with the QA department had developed clinical indicators that assisted DSSLC in establishing facility systemic trends. Among the clinical indicators that continued to be reviewed by the PNMC on a monthly basis were:<br>• Hospitalizations<br>• ER visits<br>• Deaths<br>• Skin Integrity<br>• Enteral Nutrition<br>• Aspiration Pneumonia<br>• Pneumonia<br>• Incidence of infections<br>• Falls<br>• Diabetes Management Report<br>• Individuals followed by PNMT and the PNMT's level of involvement<br>• UTIs<br>• Pseudomonas<br><br>The PNMC meeting attended on 1/16/14 contained active conversation by all members of the committee, as well as review of systems issues in an effort to have a positive impact on care at a facility level.. The PNMC analyzed trends and developed action plans to either address the issue or investigate further into the root cause of the identified concern. 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. | |
| O2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having | **Identification of PNM risk**<br>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 remaining individuals did not have PNMPs and 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)<br><br>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 | Noncompliance |

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| | 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. | swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems").<br><br>DSSLC continued to show improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM.<br><br>Eleven of 12 individuals in Sample O.1 (92%) 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).<br><br>**Physical and Nutritional Management Team Referral Process**<br>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:<br>• Aspiration Pneumonia<br>• Recurrent Pneumonia<br>• GI Issues<br>• Fractures<br>• Skin Integrity Issues<br>• Seizures<br><br>The PNMT would always review:<br>• Initial or proposed enteral tube placements<br>• Aspiration Pneumonias<br>• Choking incidents requiring physical intervention<br>• Significant unplanned weight loss<br>• Recurrent Pneumonia<br>• Fractures of long bone, skull or hip<br>• Unresolved vomiting<br>• Delayed healing of Stage 2 or Stage 3 or 4 decubitus<br><br>In 12 of the 12 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.<br><br>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 | |

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| | | 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.<br><br>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.<br><br>QA issues relevant to physical and nutritional issues were addressed by the Physical and Nutritional Management Committee (PNMC). Clinical Indicators were reviewed quarterly. For more information see above in Provision O.1.<br><br>No individuals from Sample O.1 received a feeding tube (not on an emergency basis) since the last review; however, one individual residing at DSSLC did receive a feeding tube since the last review. Per review of the PNMT minutes, there was evidence of PNMT discussion prior to receiving the feeding tube.<br><br>No individuals at DSSLC received an emergency feeding tube placement since the last review.<br><br>**PNMT Assessment**<br>Five of five 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.<br><br>Zero of one PNMT assessments completed in Sample O.2 (0%) were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. Individual #581 was referred to the PNMT on 7/25/13 but the PNMT assessment was not completed until 10/4/13.<br><br>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 | |

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| | | 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.<br><br>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:<br>• One of one (100%) contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment. The four individuals not listed in this sample were seen by the PNMT in response to a hospital return.<br>• Five of five (100%) contained date assessment was initiated. This information was contained within the PNMT assessment, PNMT minutes, or Habilitation Therapies Assessments.<br>• Five of five (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment.<br>• Five of five (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.<br>• Five of five (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.<br>• Five of five (100%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition.<br>• Five of five (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.).<br>• Five of five (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.).<br>• Five of five (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.).<br>• Five of five (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). | |

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| | | • Five of five (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. Evidence of evaluation of general posture was noted as part of the Habilitation Assessment, and PNMT RN Assessment.<br>• Five of five (100%) contained evaluation of current adaptive equipment. This information was contained within the Habilitation Assessment as well as the PNMT minutes.<br>• Five of five (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. A concern noted was while the nutritional assessments were available for review by the PNM, the majority of annual nutritional assessments were not provided in a timely manner for review by the IDT.<br>• One of five (20%) 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.<br>• Zero of three (0%) who received enteral nutrition had identified residual thresholds, for return to the PNMT.<br>• Two of two (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. The two individuals contained within this sample did not receive enteral nutrition and therefore required a tableside oral motor/swallowing assessment.<br>• Five of five (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting<br>• One of five (20%) 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.<br>• One of five (20%) 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.<br>• Five of five (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.<br>• One of five (20%) 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. | |

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| | | • Five of five (100%) contained evidence of observation of the individuals' supports at their home and day/work programs.<br>• Five of five (100%) contained evidence that the PNMT conducted hands-on assessment and/or review.<br>• Five of five (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.<br>• Five of five (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.<br>• Five of five (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.<br>• Five of five (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 minutes.<br>• Four of five (80%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP).<br>• Five of five (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT/IDT.<br>• Five of five (100%) contained signatures with dates.<br><br>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. In order to understand the etiology of the PNM event, one must review all indicators for potential impact.<br><br>In order for DSSLC to move towards substantial compliance, the IDT must ensure that all relevant areas which could have resulted in the PNM issue are reviewed as part of the ISPA.<br><br>Other concerns noted were that if the individual was not referred to the PNMT, assessments were not always completed as identified by the IDT. For example:<br>• Individual #211 has a history of repeated emesis and respiratory illnesses but | |

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| | | there was no evidence of a Head of Bed Assessment or review by the PT to determine if the current degrees of elevation remained appropriate.<br>• Individual #243's IDT recommended the OT re-assess Head of Bed elevation post Aspiration Pneumonia but there was no evidence that this occurred.<br><br>To help address comprehensiveness of evaluations, DSSLC developed an audit process in which the HT Director would audit the PNMT assessments and minutes once monthly. It is important that the audit not only look at if components are present but also if the components are comprehensive and address the reason for referral.<br><br>**Integration of PNMT Recommendations into IHCPs and/or ISPs**<br>For zero of five individuals (0%) 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:<br>• Individuals #243 and #305 had PNMT thresholds established but these were not included as part of the IHCP.<br><br>In order for DSSLC to move towards substantial compliance, thresholds and recommendations from the PNMT must be clearly linked and included within the IHCP. It should be noted that a Corrective Action Plan was developed as of 12/4/13 to address integration of PNMT recommendations.<br><br>While thresholds were noted to be developed by the PNMT, thresholds were not always clear, appropriate or sensitive enough to ensure proper referral with its occurrence. For example: Individual #211's threshold was "hospitalizations/aspiration occurring not as a result of emesis or a hospitalization occurring that was not a result of an aspiration." This type of threshold appears to be accepting of the fact that the individual will develop aspiration pneumonia. This type of threshold results in the individual not being reviewed until a possibly preventable adverse outcome occurs, although they may be experiencing PNM related issues.<br><br>Plans resulting from PNMT recommendations for Sample O.2 included the following components:<br>• In five of five (100%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment.<br>• For one of one individual (100%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans.<br>• In five of five (100%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. | |

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| | | • In five of five (100%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored.<br>• In five of five (100%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. This was included as part of the IHCP.<br>• In five of five (100%) individuals' plans reviewed, the plans defined triggers as indicated.<br>• In zero of five individuals' plans reviewed (0%), the frequency of monitoring was included in the plans.<br><br>**PNMT Follow-up and Problem Resolution**<br>With regard to plan implementation for individuals in Sample O.2:<br>• In five of five (100%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization.<br>• In five of five (100%) individuals' plans reviewed, 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.<br><br>**Individuals Discharged from the PNMT**<br>For individuals discharged by the PNMT in Sample O.2:<br>▪ One of one individual (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT.<br>▪ One of one individual's (100%) discharge summaries/action plans provided objective clinical data to justify the discharge.<br>▪ Zero of one individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP.<br>▪ One of one individuals' ISPA documentation and/or action plan (100%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. While the identification of thresholds for referral had improved, the issue was that the thresholds were not integrated in the IHCP.<br><br>A clear, consistent process existed 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 existed.<br><br>Missing was a process to ensure criteria for referral back to the PNMT was integrated as | |

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| | | 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 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. | This provision was found to be in substantial compliance. The PNMPs were comprehensive and were felt to contain the information needed to guide staff in mitigating the risks associated with physical and nutritional decline. Consistency of the plans regarding comprehensiveness as well as DSSLCs ability to update the plans as indicated in a timely manner had shown significant improvement.<br><br>**Identification of Individuals Requiring a PNMP**<br>For the twelve individuals in Sample O.1, twelve of their annual ISPs (100%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. Disciplines needed to attend the ISPs were identified as part of the pre-ISP meeting and included at least one member of Habilitation Therapies. For 12 of these 12 (100%) individuals. the disciplines noted during the pre-ISP were present at the annual IISP meeting.<br><br>The Monitoring Team determined that due to the extensive cross training that occurs regarding physical and nutritional supports, having a minimum of one therapist at the ISP is a reasonable approach to managing staff time without sacrificing the comprehensiveness of services.<br><br>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.<br><br>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 remaining individuals did not have PNMPs and 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)<br><br>**PNMP Format and Content**<br>A review of individuals' PNMPs from Samples O.1 and O.2 found:<br>• PNMPs for 12 of 12 individuals (100%) were current within the last 12 months.<br>• PNMPs for 12 of 12 individuals (100%) included a list of all high-risk levels and individual triggers as indicated.<br>• In 12 of 12 most current PNMPs (100%), there were large and clear color photographs with instructions. | Substantial Compliance |

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| | | • 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.<br>• 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.<br>• In 12 of 12 PNMPs (100%), positioning was adequately described per the individuals' assessments.<br>• In 12 of 12 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent.<br>• In 12 of 12 PNMPs (100%), bathing instructions were provided.<br>• In 12 of 12 (100%) PNMPs, toileting-related instructions were provided, including check and change.<br>• 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.<br>• In 12 of 12 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition.<br>• Twelve of 12 individuals' (100%) Dining Plans were current within the last 12 months.<br>• Seven individuals had feeding tubes with no oral intake. Seven of seven (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth.<br>• 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.<br>• In five of five PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included.<br>• In five of five PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified.<br>• In five of five 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.<br>• In 12 of 12 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency.<br>• In 12 of 12 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions.<br>• Twelve of 12 PNMPs (100%) included information related to communication | |

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| | | (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.<br><br>**<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>**<br>For four individuals in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP, four ISPA meeting documentations (100%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. Discussion was clearly noted as part of the ISPA/PNMT minutes and was based on recommendations from completed assessments.<br><br>For individuals for whom the PNMP was revised, there was supporting documentation that four of four individuals' (Sample O.1) revised PNMPs (100%) had been implemented.<br><br>Per review of the Medication Administration Records (MARs), Dining Plans, and PNMPs in the "Me" books for the four individuals who required changes to the PNMP, all PNMPS were updated and consistent. This was much improved since the previous visit when less than 30% were noted to be revised and consistent across locations. | |
| O4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties. | **<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u>**<br>Staff did not engage in safe mealtime practices, as indicated by the following:<br><br>Per observations conducted by the Monitoring Team, eight of 15 individuals' (53%) dining plans/PNMPs were implemented as written.<br><br>Examples of dining plans not implemented included but were not limited to:<br>• Individual #398 was not encouraged to take sips of liquids after every 2-3 bites to help clear oral cavity resulting in an increased risk of aspiration and/or choking. This was a repeat issue noted form the previous compliance visit.<br>• Individual #189 was observed taking large bites when the plan called for staff to ensure that Individual does not over fill spoon in an effort to mitigate risk of choking.<br>• Individual #534 was observed not in his specialized dining chair and had no access liquids for 10 minutes into his meal thus increasing risk of choking.<br><br>Based on observations by the Monitoring Team:<br>One of five individuals' positioning plans (20%) was 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 | Noncompliance |

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to the risk of skin breakdown, aspiration, and pneumonia. Examples of non-implementation included:

- Individual #355 was observed in bed with no pillow between legs and knees resulting in increased risk of skin breakdown and contractures due to poor positioning.
- Individual #602 was observed in recliner slumped forward and leaning heavily to his right resulting in increased abdominal compression and decreased ability to expand lungs thus resulting in an increased of aspiration. It should be noted that individual was receiving enteral nutrition at the time of the poor positioning.

Transfers were improved and observations noted:

- Two of two individuals' transfer plans (100%) were implemented as written.

During one of one observation of medication administration (100%), the nurse followed procedures in the PNMP.

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.

**Knowledge of Staff Regarding PNMPs**

Staff Interview: Staff were not consistently knowledgeable of the individuals' PNMPs. Based upon interviews with ten staff from Eastfield, Cedar Falls, and Garden Ridge, knowledge of staff had decreased and was not sufficient to ensure correct implementation. Following are the numbers of staff who answered correctly and the number asked the question:

| | # Asked | # Correct | % Correct |
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| Positioning: | | | |
| How do you know the individual is in the correct position in their wheelchair/bed? | 8 | 5 | 63% |
| | | | |
| Mealtimes: | | | |
| For what reason does the individual have thickened liquids? | 8 | 7 | 87% |
| For what reason does the individual eat a modified texture? | 8 | 7 | 87% |

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
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<tr><td>What is the reason for the individual using a specific utensil?</td><td>8</td><td>4</td><td>50%</td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>8</td><td>4</td><td>50%</td></tr>
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</td><td></td></tr>
<tr><td>O5</td><td>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.</td><td>
<u>New Employee Orientation (NEO)</u><br>
The PNM related core competencies (i.e., foundational skills) were comprehensive. NEO orientation included the following elements:<br>
▪ Physical Management and Mealtime Training<br>
▪ Lifting People, Transfers and Assistive Equipment<br>
▪ Preventing Aspiration<br><br>
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 and were current with their annual refresher courses were as follows.<br>
• Lifting People-1457/1473 (99%)<br>
• Physical Management-1610/1655 (97%)<br>
• Preventing Aspiration/Mealtime Training-1328/1473 (90%)<br><br>
<u>PNM Core Competencies for Current Staff</u><br>
Forty-eight of 48 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:<br>
▪ Mealtime<br>
▪ Physical Management<br>
▪ Lifting People<br><br>
<u>Annual Refresher Training</u><br>
As of 11/19/13, staff that requires training had completed annual refresher competency-based training and performance check-offs within the last 12 months.<br>
▪ Lifting People: 99% completion rate<br>
▪ Preventing Aspiration/Mealtime: 90% completion rate<br><br>
Per PNM policy, training will be provided at least annually and as indicated by monitoring. At the time of the review, the only trainings provided annually were “Lifting People” and “Preventing Aspiration.”
</td><td>Noncompliance</td></tr>
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| | | **Individual-Specific Training**<br>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 three 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 that while DSSLC had implemented a clear start date of the training documented, the Monitoring Team remained 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. Additionally, it was unclear as to what percentage had been trained as the staff list for the home was not included or referenced as part of the training documentation.<br><br>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 is trained.<br><br>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.<br><br>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 had themselves been provided with the needed competency based training prior to training other staff.. This could be accomplished by having the trained instructor be listed as the first person trained on the provided roster and identified as the trainer.<br><br>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 change in status. This will be reviewed at the next compliance visit. | |

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| | | DSSLC remained 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:<br>• 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/are 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.<br>• 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.<br>• Level 3: These individuals either do not have a PNMP or have a simple PNMP with no specialized instructions.<br><br>The individual's levels would be initially determined based on consultation by the Director of Habilitation Therapies and other professional staff. As of this review, there was only one individual who was identified as level 1.<br><br>While individuals who are Level 2 may not require staff to have competency-based training outside of what was provided during NEO, there remains a need to document that information regarding the individual's PNMP was shared and understood by the pulled staff. | |
| O6 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans. | **Facility's System for Monitoring of Staff Competency with PNMPs**<br>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. DSSLC had added a guideline that stated that if implementation was not noted then a score of "Noncompliance" was automatic.<br><br>Monitoring tools included adequate instructions/guidelines. The State Supported Living Center Compliance Monitoring Form had guiding questions regarding what the staff | Noncompliance |

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| | | 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). Per interview with the HT Director, review of monitoring data revealed the process for informing the IDT and developing corrective action plans based off of monitoring information was not working due to the complexity of the process. During the first quarter of 2014, the process will be re-assessed in order to develop a new monitoring process.<br><br>Staff conducting monitors consisted of the Occupational Therapists (OTs), Certified Occupation Therapy Assistants (COTA), Physical Therapists (PT), and Physical Therapy Assistants (PTA). Twenty four of 24 therapists and assistants (100%) were trained and competent to perform the monitors. A process existed in which a PNMT member would observe the therapist every six months for inter-rater reliability. The process was as follows:<br><br>Inter-Rater reliability would be calculated by the QA/QI Department. Calculations that were above 80% would be repeated every six months. Calculations that fall below 80% would be repeated monthly until they reach a level above 80%. If at any time someone who reached the 80% or above level showed signs that their monitoring was becoming less accurate, then the inter-rater reliability would need to be repeated before the six month mark. The QA/QI department would keep track of when the inter-rater reliability needs to be repeated and who needs to repeat it.<br><br>Inter-rater checks completed over the past six months were as follows;<br>• 16/20 (80%) inter-rater reliability checks were completed in the past six months.<br>• 4/16 (25%) of those completed will need to be repeated due to the scores falling below the threshold of 80%.<br>• Of those 4, three are OTAs and one is a PT. One OTA repeated the inter-rater reliability check on 11/21/13 with a 100% on both compliance and efficacy.<br>• The four staff who have yet to complete the inter-rater reliability check are 2 OTs, 1 PT, and 1 PTA.<br><br>A graph showing the approximate percentage of areas monitored for PNM during the months of August, September and October provided information as follows: | |

| | Bathing | Lifting/Transfer | Meal | Med Admin | Oral Care | Positioning | Snack |
|---|---|---|---|---|---|---|---|
| 8/13 | 0% | 0% | 50% | 27% | 0% | 0% | 23% |
| 9/13 | 0% | 0% | 40% | 32% | 6% | 17% | 2% |

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| 10/13 | 0% | 0% | 0% | 0% | 100% | 0% | 0% |

The above graph demonstrated that all areas in which difficulties are likely to be provoked were not receiving adequate monitoring. Another issue noted was that no monitoring occurred on third shift. The risk of PNM issues are not limited to first and second shift and while it is not expected that third shift will have the same frequency of monitors, the need for some level of formal monitoring exists.

In order to move towards substantial compliance, DSSLC will need to ensure that all areas which are likely to provoke PNM issues are monitored. Additionally, all times/shifts should be represented.

**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 10/4/13) 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 3/15/13) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. Per the HT Director, DSSLC had attempted to provide monitoring once monthly for high risk and quarterly for moderate risk but the numbers were too large to complete. DSSLC was in the process of reviewing the system and developing new standards.

As stated above in O.6 "Facility's System for Monitoring of Staff Competency with PNMPs", there was not a functional system in place that ensured appropriate follow up if a deficiency was noted during the provided monitor.

In order to move towards substantial compliance, DSSLC will need to develop a functional monitoring database that will be sufficient in drawing a conclusion regarding the effectiveness of the PNMPs as well as staff implementation rates.

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| O7 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate. | **IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans**<br>Thirteen of the 13 individuals' records (100%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. Zero of 13 (0%) IHCPs contained criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy).<br><br>One of the 13 individuals' records in Samples O.1 and O.2 (7%) 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. QIDP 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.<br><br>Thirteen of 13 individuals' records (100%) 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.<br><br>Zero of three Trigger sheets (0%) were completed correctly.<br><br>Zero of three Trigger sheets (0%) were reviewed at a minimum daily by the appropriate shift RN.<br><br>Issues with the Aspiration Trigger Sheet included:<br>• The trigger sheets contained multiple gaps in data due to lack of completion.<br>• Triggers when occurred were not consistently documented on the trigger sheet.<br>• Nursing and Case Manager Review of the trigger sheet was inconsistent.<br>• Triggers captured on the trigger sheet did not match triggers on the PNMP. For example, Individual #305 had listed on the PNMP the trigger "increase in temperature 24-48 hours post vomiting episode" but this was not tracked as part of the trigger sheet. | Noncompliance |
| 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 | **Evaluation of Individuals who receive Enteral Nutrition**<br>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. | Noncompliance |

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| | 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. | Eight of eight 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.<br><br>Eight of eight individuals (100%) evaluated had an appropriate evaluation to determine the medical necessity of the tube.<br><br>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).<br><br>Two individuals who received enteral nourishment were admitted since the last review; and were reviewed to determine the medical necessity of the feeding tube within 30 days.<br><br>**Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition**<br>Zero of eight 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.<br><br>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.<br><br>DSSLC did not consistently provide treatments or strategies to help move the individual along the pathway to oral intake. Examples included:<br>• Individual #211 has difficulty managing his secretions but there was no discussion or investigation as to if he would benefit from therapy.<br><br>At the time of the review, no individuals were receiving oral motor therapy and therefore indicators regarding treatment plans and oral intake plans were unable to be reviewed. This included whether:<br>• Individuals 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.<br>• Individuals' plans to return to oral eating or improve oral eating were based on the results of the IDT's discussion (0%) and were integrated in the IHCP, ISP, | |

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| | | and/or an ISPA. While it was based on IDT discussion, there was no evidence of integration into the IHCP.<br>• Individuals' 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.<br>• The plan did not include the following components:<br>o Staff roles and responsibilities (e.g., implementation, monitoring);<br>o Time and schedule of interventions;<br>o Specific triggers for when the plan should be stopped;<br>o Milestones for progressing with the plan;<br>o Documentation requirements (method for tracking progress); and<br>o Frequency of subsequent assessments and staff responsible.<br><br>Eight of eight 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 have discussion of oral motor treatment.<br><br>In order to move towards substantial compliance, DSSLC must improve its assessment of individuals who may benefit from oral motor improvement through therapy and provide the plans needed to not only move towards potential oral intake but to address other issues (e.g., salivary control). | |

| SECTION P: Physical and Occupational Therapy | |
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| Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below: | **Steps Taken to Assess Compliance:**<br>1. DSSLC Self Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. Presentation Book for Section I, Section O, and Section P<br>4. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 10/4/13)<br>5. DSSLC Policy CC-04 Physical and Nutritional Management Committee (10/1/2013)<br>6. Treatment Documentation Procedure (rev: 10/22/13)<br>7. Occupational/Physical Therapy Audit Process (rev: 11/8/13)<br>8. DSSLC PNMT Process Flow Chart (10/17/13)<br>9. Universal Monitoring Plan rev: 3/15/13<br>10. Wheelchair Repair Log 10/2013<br>11. Record reviews:<br>a. Sample P.1: Individuals #170, #187, #209, #211, #243, #305, #392, #402, #414, #463, #499, and #689<br>b. Sample P.2: Individuals #13, #32, #463, #583, and #630<br>12. A list of all therapy and/or clinical staff—occupational therapists (OT), physical therapists (PT), speech and language pathologists (SLP), dietitians (RD), and Physical and Nutritional Management team (PNMT) members, including credentials<br>13. A list of continuing education sessions or activities participated in by PNMT members since last review (7/2013)<br>14. Current Lists of people:<br>(a) Who use wheelchair as primary mobility;<br>(b) With transport wheelchairs;<br>(c) With other ambulation assistive devices, including the name of the device;<br>(d) With orthotics and/or braces;<br>(e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution;<br>(f) Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury.<br>15. OT/PT assessments template and guidelines<br>16. 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.<br>17. List of individuals receiving direct OT and/or PT services and focus of intervention.<br>18. List of ten individuals with the most falls since the last compliance review<br>**People Interviewed:**<br>1. Paula Horn PT Director of Habilitation Therapies<br>2. Eight DCPs (Timberhill, Cedar Falls, Eastfield, Garden Ridge)<br>**Meeting Attended/Observations:**<br>1. Physical and Nutritional Management Team 1/16/14 |

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| | 2. Physical and Nutritional Management Committee 1/16/14<br>3. Mealtimes and Transitions- Timberhill, Cedar Falls, Garden Ridge, and Eastfield |
| | **Facility Self-Assessment:**<br>For Section P in conducting its self-assessment:<br>▪ 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:<br>o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P.<br>o This monitoring/audit tool did include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>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.<br>▪ The Facility rated itself as being not in compliance in all the provisions of Section P. This was not consistent with the Monitoring Team's findings of substantial compliance with section P.1.<br><br>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:**<br>DSSLC continued to show 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. Concerns were noted regarding the comprehensiveness of review and determination of services in the occurrence of a change in status.<br><br>**Provision P.1:** This provision was identified as being in substantial compliance. The vast majority of the assessments were noted to be comprehensive and address all generalized standards of a comprehensive assessment. Although six components were identified as being below the 90% criteria, the Monitoring Team observed a significant improvement in the overall comprehensiveness of the assessment. Four of the five (80%) components that were lacking were much improved and well above the 90% criteria since the assessment format was revised in October 2013. The exception was inclusion of the monitoring schedule which was still below the needed criteria at 50%. It is expected that DSSLC will take the needed steps to ensure the progress noted with all components continues in order to maintain substantial compliance.<br><br>**Provision P.2:** This provision was determined to be not in compliance. 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 |

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| | 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. Additionally, indirect plans of care were not consistently implemented by staff.<br><br>**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.<br><br>**Provision P.4:** This provision was determined to be not in compliance. A formal monitoring system was not fully implemented that allowed for the adequate monitoring of OT/PT supports. |

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| P1 | By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner. | All requirements of this provision were identified as being in substantial compliance. The vast majority of the assessments were noted to be comprehensive and address all generalized standards of a comprehensive assessment. The only component that was not fully present was regarding a clear statement regarding the monitoring schedule and information that would guide the IDT towards the development of OT/PT related skill acquisition. It should be noted that since the assessment was revised in October 2013, four of four assessments (100%) included these components and should serve as a valuable asset to the IDT in developing ADL related Skill Acquisition Programs (SAPs). It is the expectation that the components that were not fully implemented or missing will be addressed and implemented by the next compliance visit in order to maintain substantial compliance. It is the expectation that all components that were below the 90% threshold will be improved so that they reach the 90% mark needed to sustain substantial compliance.<br><br>Samples for this section were as follows:<br><br>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). | Substantial Compliance |

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| | | Sample P.2 consisted of five individuals who receive direct OT/PT services that was chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy.<br><br>**Timeliness of Assessments**<br>Seven of seven admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission.<br><br>Seven of seven individuals (100%) admitted since the last received a comprehensive OT/PT assessment within 30 days of admission. DSSLC does not do screening upon admission for OTs and PTs but, instead, conducts a comprehensive OT/PT assessment. The Monitoring Team considers the presence of assessments as meeting and surpassing compliance with this metric.<br><br>Fifteen of 16 individuals' OT/PT assessments in Samples P.1 and P.2 (94%) were dated as having been completed at least 10 days prior to the annual ISP.<br><br>Sixteen of 16 assessments or updates in Samples P.1 and P.2 (100%) were current within 12 months for individuals who are provided PNM supports and services.<br><br>**OT/PT Assessment**<br>Based on review of the sample of assessments and updates (all reviewed for comprehensiveness using the standards below), the comprehensiveness of the OT/PT assessments for Samples P.1 and P.2 were as follows:<br>• Sixteen of 16 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report.<br>• Fifteen of 16 assessments (94%) included diagnoses and relevance to functional status.<br>• Sixteen of 16 assessments (100%) included a section that reported health risk levels that were associated with OT/PT supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels.<br>• Thirteen of 16 assessments (81%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. It should be noted that since the assessment was revised in October 2013, all the assessments included a clear analysis of the individual's level of functional status. . Based on this review four of four (100%) completed post October 2013 contained this component.<br>• Thirteen of 16 individuals' OT/PT assessments (81%) offered a comparative analysis of current functional motor and activities of daily living skills with | |

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| | | previous assessments. It should be noted that since the assessment was revised in October 2013, all the assessments included a clear analysis of the individual's level of functional status. . Based on this review four of four (100%) completed post October 2013 contained this component.<br>• Sixteen of 16 assessments (100%) included medical history and relevance to functional status.<br>• Sixteen of 16 assessments (100%) addressed health status over the last year<br>• Sixteen of 16 assessments (100%) listed medications and potential side effects relevant to functional status.<br>• Fourteen of 16 assessments (88%) included documentation of how the individual's risk levels impact their performance of functional skills.<br>• Sixteen of 16 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work).<br>• Fifteen of 16 assessments (94%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings.<br>• Five of 16 assessments (33%) included discussion of the individual's potential to develop new functional skills. The OT/PT assessment should discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs. It should be noted that since the assessment was revised in October 2013, all the assessments have contained a section titled "Skill Acquisition" that included recommendations for enhancing skills. Based on this review four of four (100%) completed post October 2013 contained this component.<br>• Sixteen of 16 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This was primarily included as part of the PNMP.<br>• Twelve of 16 assessments (75%) 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. A concern was noted with individual #243 who was noted to have increased tone and decreased grasp but no recommendation was made to determine etiology or plan developed to address decline. It should be noted that since the assessment was revised in October 2013, all the assessments included whether the individual required direct or indirect services. Based on this review, four of four (100%) completed post October 2013 contained this component<br>• Zero of 16 assessments (0%) included evidence of the Individual's monitoring schedule. A section existed within the assessment since October 2013 but the information contained within that section still did not consistently provide | |

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| | | information regarding the monitoring schedule. For example, Individual #392's monitoring section only stated "QIDP/Life Skills" and provided no more information regarding frequency. Based on the sample of assessments drawn since the assessment was revised in October 2013, two of four (50%), contained evidence of a monitoring schedule. This area must be addressed and be presently sufficient in order for DSSLC to maintain future substantial compliance with this section.<br>• Sixteen of 16 assessments (100%) included a re-assessment schedule.<br>• Sixteen of 16 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information continued to improve as more detailed requirements were now included as part of the overall determination.<br>• Sixteen of 16 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living.<br>• Sixteen of 16 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.<br>• Sixteen of 16 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement."<br>• Sixteen of 16 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP.<br><br>Although six components were identified as being below the 90% criteria, the Monitoring Team observed a significant improvement in the overall comprehensiveness of the assessment. Four of the five (80%) components that were lacking were much improved and well above the 90% criteria since the assessment format was revised in October 2013 (i.e., the new procedures appeared to be established and consistently implemented for three months). The exception was inclusion of the monitoring schedule which was still below the needed criteria at 50%. It is expected that DSSLC will take the needed steps to ensure the progress noted with all components continues in order to maintain substantial compliance.<br><br>Since the last review, DSSLC had developed a more formal audit process in which the OT/PT assessment of assessment would be audited for comprehensiveness 7 times per month (1 per unit) as well as 10% of OT Treatment notes and 10% of PT treatment notes per month. All audits would be completed by the contract OT. | |

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| | | It is important that the audit not only look at if components are present but also if the components are comprehensive and address the reason for referral. | |
| P2 | Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression. | **OT/PT Interventions**<br>For individuals receiving OT/PT supports and services, 16 of 16 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.<br><br>For 16 of 16 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.<br><br>**Direct OT/PT Interventions**<br>The records of individuals in Sample P.2 were reviewed resulting in the following findings:<br>• Five of five 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.<br>• For five of five individuals' records (100%) 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.<br>• For four of five individuals' records (80%) 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 for the most part were clearly included as part of the OT/PT plan of service. An example of a goal that was not measurable was for Individual #32 whose goal simply stated to "increase overall functional range of motion, strength, and endurance to improve overall posture while seated and walking".<br>• For one of one individual's records (100%), whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner.<br><br>**Indirect OT/PT Programs**<br>The implementation of these plans is discussed under Section O4 for PNMPs.<br><br>**Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP**<br>An OT or PT attended the ISP or ISPA meeting, unless adequate justification was | Noncompliance |

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| | | provided in the Pre-ISP meeting documentation. Fifteen of 16 ISP annual meetings (94%) had a member from either OT or PT present to represent the disciplines.<br><br>Sixteen of 16 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.<br><br>Skill acquisition programs were not consistently recommended in the OT/PT assessments; therefore, the Monitoring Team was unable to fully determine if these were integrated into the ISP. It should be noted that two of two (100%) assessments completed post October 1, 2013 did contain opportunities for skill acquisition and these were noted to be included and integrated into the ISP with 100% accuracy.<br><br>Five of five individuals receiving direct OT/PT Services (Sample P.2) (100%) were provided with comprehensive progress notes (IPNs) that contained all of the indicators listed below. This represented an increase of 90% since the previous compliance visit. Progress notes included the following indicators:<br>• 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).<br>• Reported the consistency of implementation.<br>• Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress.<br>• 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.<br>• A comprehensive progress note was completed on at least a monthly basis.<br><br>To address the above standard, DSSLC developed a template for therapists to utilize when writing their progress notes. Based upon the sample drawn, the development of the template was positive step forward and had resulted in improved consistency and comprehensiveness of the progress notes.<br><br>For individuals with PNMPs or SAPs, for two of 11 individuals in Sample P.1 (one was omitted from sample as the individual was receiving direct treatment) (18%), 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: | |

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| | | • 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);<br>• A description of the benefit of the program;<br>• Identification of the consistency of implementation; and<br>• Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.<br><br>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.<br><br>In order to move towards substantial compliance, there must be evidence that the PNMP is reviewed as part of the QDDP's monthly review with information containing the above components. | |
| P3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans. | 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 PNMP. | Noncompliance |
| P4 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of | **Monitoring System**<br>The Facility did not implement a system for the adequate monitoring of PNMPs.<br>• See Provision O.6<br><br>The Universal Monitoring Plan (revised 3/15/13) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. Per the HT Director, DSSLC had attempted to provide monitoring once monthly for high risk and quarterly for moderate risk but the numbers were too large to complete. DSSLC was in the process of reviewing the system and developing new standards.<br><br>In order for the Facility to move towards substantial compliance, a monitoring system must be developed and formalized that will ensure supports and services are reviewed.<br><br>An Inter-rater reliability process was developed by DSSLC that was provided with the | Noncompliance |

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| | each individual; and the implementation by direct care staff of these interventions. | following frequency:<br>• OT/PT assessment of assessment=1 per quarter completed by HT Director<br>• Treatment note audit=1 per quarter OT, 1 per quarter PT completed by HT Director<br>• PNMT assessment of assessments=1 per quarter completed by contract OT<br>• PNMT audit of meeting minutes=1 per quarter completed by contract OT<br><br>The Facility did have a comprehensive OT/PT policy. The policy included the following elements:<br>• Description of the role and responsibilities of OT/PT;<br>• Referral process and entrance criteria;<br>• Discharge criteria;<br>• Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs;<br>• Includes re-evaluation of monitors on an annual basis by therapists and/or assistants;<br>• Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor;<br>• Identifies the frequency of assessments;<br>• Defines how individuals' OT/PT needs will be identified and reviewed; and<br>• Sets forth documentation expectations for individuals receiving direct services<br>• Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual;<br><br>Additionally, DSSLC had developed a process for auditing assessments, providing inter-rater reliability and ensuring proper documentation in the IPNs.<br><br>For 16 of 16 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.<br><br>For 16 of 16 individuals (100%), positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. | |

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| | | Per review of the Wheelchair Repair Log (10/2013), for 196 of 196 incidents in which 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 if the issue impacts the individual's health or safety, then action was taken within 48 hours. | |

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self Assessment, 12/27/2013<br>2. DSSLC Action Plan, 12/5/13<br>3. DSSLC Presentation Book DSSLC Dental Services, Dental X-rays – DS-23, 8/1/2011<br>4. DSSLC Dental Policy for Dental Emergencies - dental services Overview DS-09, dated 12/11/2012<br>5. DSSLC Dental Care – Suction Toothbrushing Protocol DS-04; 04/23/2013<br>6. DSSLC Dental Services Quality Assurance Policy DS-25, dated 9/11/2012<br>7. DSSLC policy for Dental Services IV Sedation DS-24, dated 8/1/2011<br>8. List of all dental office staff<br>9. List of continuing education for dental professionals<br>10. List of all individuals who were not current with necessary dental imaging studies<br>11. Copy of recent imaging reports for Individuals #35, #15, #5, #10, #1, #790, #791, #793, #75, and 799<br>12. For Individuals #1, #5, #10, #15, and #35:<br>a. Current individual service plan (ISP)<br>b. Most recent annual dental assessment<br>c. Most recent PMNP<br>13. List of all dental emergencies that occurred during the reporting period<br>14. For Individuals #742, #366, #311, #764, and #273:<br>a. Dental progress notes associated with the dental emergency<br>b. IDT meeting minutes documenting the dental emergency<br>c. Integrated progress notes (IPNs) documenting nursing and medical providers' intervention specific to the dental emergency<br>15. For Individuals #1, #, #10, #15, and #35:<br>a. Most recent integrated risk rating form (IRRF)<br>b. Most recent physical nutritional management plan (PNMPs)<br>c. Most recent annual dental assessment<br>16. DSSLC Dental Services Oral Care Policy – DS 03, dated 08/1/2011<br>17. List of all restorative treatments provided during the review period<br>18. List of individuals who had not completed restorative dental treatments<br>19. For Individuals #185, #86, #198, #32, and #134:<br>a. Most recent IRRF<br>b. Most recent annual ISP<br>c. Most recent PNMP<br>20. QAQI Council Data Meeting minutes for 9/24/2013 and 12/17/2013<br>21. Dental audit listing/desensitization information, revised 1/7/2014<br>22. For Individuals #170, #474. #430, #534, #204, #123, #169, #2, #669, and #1:<br>a. Data, summary and ISP for program to help reduce the need for dental sedation<br>23. Dental schedule for previous and following six month period, from the time of the compliance visit |

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| | 24. Document indicating that the Facility did not require general (intubation) anesthesia for individuals at the Facility<br>25. Document by dental director that the Facility maintains adequate TIVA resources<br>26. For Individuals #705, #587, #474, #445, and #633:<br>a. All anesthesia records, and associated IPNs for dental services<br>**People Interviewed:**<br>1. Dr. Paul Nelson, DDS, Dental Director<br>**Meetings Attended/Observations:**<br>None |
| | **Facility Self-Assessment:**<br>The Monitoring Team concurs with the Facility's Self-Assessment of noncompliance for Sections Q.1, and Q.2.<br><br>The Facility's Self-Assessment documented collection of data for many of the Facility's actions for dental services; however, the Self-Assessment did not attempt to assess the quality of dental services, or outcomes secondary to dental services. For example, the Self-Assessment reported percentages of individuals completing specific services, such as completing an annual dental examination or restorative treatment, as well as the percentages of no shows and dental refusals. The Facility did not assess specific issues associated with dental no shows, such as staff shortages, transportation issues, or lack of necessary professional services; having this information could help in developing improvement plans. Also, the Facility did not assess the effectiveness of staff's provision of suction toothbrushing or oral hygiene at the living area. The Facility indicated that 100% of PNMPs incorporated dental positioning, and the Monitoring Team concurred with that assessment; however, there was no evidence of documentation in PNPMs or other records available to direct support staff of other pertinent issues related to providing oral hygiene, such as specific monitoring and reporting parameters, and specific frequency of toothbrushing and flossing needs. There was no self-assessment to determine if the Facility had adequate TIVA services, or if the Facility was appropriately monitoring individuals who undergo sedation. There was also no Self-Assessment of the Facility's dental QA process, to determine if the Facility was appropriately monitoring individuals for potential adverse outcomes following sedation. |
| | **Summary of Monitor's Assessment:**<br>The Monitoring Team determined that the Facility maintained adequate staffing for its dental office, and that the Facility had effective professional, and support staff. There was substantial evidence demonstrating the annual dental examinations, dental hygiene, and restorative treatments were provided timely. The Facility did not, however, have effective processes in place to ensure necessary supports and services to provide oral healthcare at the living area. The Facility also lacked an effective method to track and trend dental services and dental scheduling. The following are some observations, and comments specific to Sections Q.1, and Q.2.<br><br>**Section Q.1:** The Facility maintains a well staffed dental department, and there was evidence to indicate that services provided by the dental professionals, such as annual evaluations, dental hygiene, and |

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| | restorative treatments, indicated that dental services are provided at the level of standard of care practice. The Facility, however, does not maintain necessary processes to ensure that oral hygiene issues at the living area are provided as necessary. The Facility must enhance its policies and procedures for oral hygiene and suction toothbrushing; develop and implement a process that assesses the efficacy of direct care staff provision of suction toothbrushing and oral hygiene at the living area; and enhance the annual ISP process to ensure that all oral health related issues are addressed, including the condition of oral and dental health, necessary treatments, necessary supports and services, risks and benefits of oral and dental health treatments, and challenges associated with the provision of oral healthcare. The IRRF and PMNP must clearly delineate all necessary treatments, including frequency of treatments, associated risks, and monitoring parameters when providing oral healthcare supports. Documentation practices for the provision of emergency dental services should be more comprehensive, by including documentation of follow-up appointments, and monitoring parameters for nursing and direct care staff to follow. Because of the issues listed above, the Monitoring Team determined noncompliance with Section Q.1.<br><br>**Section Q.2:** The Monitoring Team recognizes that the Facility provides adequate TIVA resources, and that the Facility provides clinical monitoring before, during, and post sedation. The Facility did not adopt a mechanism to efficiently track and trend dental services, or to maintain an effective dental schedule. The Facility has an effective system for evaluating the quality of dental treatments, but did not have a process to monitor and assess possible adverse outcomes secondary to dental services, such as exacerbation of maladaptive behaviors, injuries, or pneumonia. The Facility also did not provide evidence that it stratifies the reasons for missed appointments, such as illness, other medical appointments, or hospitalizations, maladaptive behaviors, and system issues such as staff shortages, communication issues, and lack of transportation, to assist in planning improvement actions. Because of these issues, the Monitoring Team determined noncompliance 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 | To assess the Facility's ability to provided oral health care needs at the Facility, the Monitoring Team reviewed 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<br><br><u>Dental Administration</u><br>At the time of the last compliance visit 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.<br><br>The Facility maintains the following dental office staff:<br>• One Full time dentist, who provided 40 hours of direct care<br>• One full time dental director. | Noncompliance |

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| | disabilities shall satisfy these standards. | • One part time contract dentist<br>• One part time contract oral surgeon<br>• Two dental hygienists, who each provided 40 hours of direct care per week<br>• Two dental assistants, who provided both administrative support and direct care<br>• One full time dental administrative assistant<br>• One contract anesthesiologist, who provided approximately ten hours of service to the Facility each week<br><br>There was no evidence that dental professionals were provided continuing education specific to the field of special needs dentistry.<br><br>The Dental director informed the Monitoring Team that the DADS dental database was not fully operational during the reporting period because of technical issues with internet connectivity; however, this issue was resolved and the dental office had recently begun using the database system.<br><br>The Monitoring Team encourages the Facility to utilize a system that will enable enhanced tracking of dental database elements, and looks forward to assessing the functionality of the current electronic dental database system, once fully implemented. The Monitoring Team recognizes that the Facility maintains appropriate professional staffing for dental services.<br><br><u>Dental Imaging</u><br>To assess the Facility's ability to provide clinically appropriate dental imaging studies, the Monitoring Team discussed the issue with the dental director, and requested documentation of completion of dental imaging studies for the first five and last five individuals on the current name key for this compliance visit.. The Facility provided a list of all individuals who had not been provided bitewing imaging studies or alternative dental imaging studies within the previous 24 months. The Monitoring Team also reviewed the current DSSLC policy for dental x-rays: DSSLC Dental Services, Dental X-rays – DS-23, 8/1/2011.<br><br>The list of all individuals who were not current with their scheduled dental imaging studies indicated that 42 individuals were not provided regularly scheduled dental imaging studies, and that 42, out of the 42 (100%) were edentulous, hence did not require regularly scheduled dental imaging.<br><br>The Monitoring Team was provided a copy of the dental progress and treatment records for Individuals #35, #15, #5, #10, #1, #790, #791, #793, #75, and #799. Individuals | |

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| | | #35, #15, #790, and #75 were not associated with the samples requested by the document request. Therefore, the review of the dental progress and treatment record notes will only be completed for the examples from the document request (Individuals #5, #10, #1, #791, #793, and #799). The review indicated that dental imaging studies had been completed, within the past 24 months, for five out of the six examples reviewed; however, the documentation did not clearly delineate the specific dental imaging studies obtained, or the results of the dental imaging studies.<br><br>The Monitoring Team noted that the Facility's dental x-ray policy had not been updated, despite the dental director informing the Monitoring Team at the last compliance visit that the policy would be revised to reflect current dental standards with regard to the frequency of dental imaging.<br><br>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, and again encourages the Facility to update its dental X-ray policy to reflect current standard of care practice.<br><br>The Facility provided a document stating that the delays with scheduled dental imaging are not reported to the IDT or documented on the annual ISP, and that no plans are developed to ensure that necessary dental imaging studies are obtained, when delinquent.<br><br>Summary: The Monitoring Team was informed at the previous compliance visit that the dental x-ray policy would be updated to reflect dental standard of care practice with regard to the frequency of dental imaging studies, but the policy was not updated. The Facility indicated that all necessary dental imaging studies were current; however, because the Facility did not provide the specific sample selection for review, the Monitoring Team was unable to verify if dental imaging studies were current. The Facility must ensure that the IDT be made aware of delays with all necessary dental imaging studies, and that compliance issues are delineated within the context of the annual ISP.<br><br><u>Annual Dental Examinations, Dental Hygiene, and Schedule for Oral Health Care</u><br>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 | |

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| | | requested for the first, and then every fifth, individual on the current name key, for a total of five examples (Individuals #1, #5, #10, #15, and #35).<br><br>The Monitoring Team was provided a list called the ISP Conference Calendar for July 2013 through December 2013. The list indicated the names, living area, and date of the scheduled ISP meeting, along with the dates of the current and previous annual dental examination for 199 individuals. Review of this list indicated that all individuals had completed their annual dental examination prior to the ISP meeting date. The Facility did indicated, by a documented called Annual Dental Exams Not Fully Completed, that 14 individuals had not fully completed their dental examination. In all 14 examples, noncompliance secondary to physical aggression was documented as the reason why the examination was not completed. The Facility did not provide a complete copy of the dental office schedule for the past and future six months dental office visits, as requested. Furthermore, the Facility provided a document indicating that "there is not a tracking system for" annual dental examinations and routine dental hygiene.<br><br>Review of the most recent IPNs, dental progress notes, PNMPs, past two annual dental assessments, and dental hygiene records for individuals #1, #5, #10, #15, and #35 indicated the following:<br>• The most recent annual dental summary was completed within 12 months or less, from the date of the previous annual dental assessment, in five out of five (100%) cases.<br>• The most recent annual dental summary was completed prior to the annual ISP meeting, in five out of five (100%) cases.<br>• The most recent annual dental assessment evaluated oral hygiene, periodontal disease, plaque, and gum health in five out of five (100%) cases.<br>• The most recent annual dental assessment assessed specific condition of teeth, including caries and tooth movement, in two out of five (40%) samples. Only two examples included a dental diagram indicating clinical issues.<br>• The most recent annual dental assessment documented the level of restraint required to perform dental examinations and treatments, in five out of five (100%) cases.<br>• The most recent PMNP documented oral health care condition, in zero out of five (0%) cases. In two examples was a document provided indicating some form of communication for the PMNP; however, in no examples was there documentation that the PNMP included the current dental condition, as at the time of the annual review.<br>• The most recent PMNP accurately reflected special requirements, such as the use of spin tooth brushes, specific types of toothpaste, mouth rinsing, flossing, and special supports, as delineated on the annual ISP, in zero out of five cases | |

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| | | (0%).<br>• The most recent annual ISP documented oral health care issues, in zero out of five (0%) cases. ISPs were not provided for review.<br>• The most recent ISP 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 zero out of five (0%) cases. ISPs were not provided for review<br>• The annual dental assessment documented when the last dental x-rays were obtained, in zero out of five (0%) samples. In two out of five examples (40%), there was a check mark indicating that dental x-rays were recommended; however, there was no indication when dental x-rays were obtained in the past, or a summary of the x-ray findings.<br>• The most recent annual dental summary included a comment about oral cancer screening in zero out of five (0%) cases.<br>• The Facility did not consistently document on the annual dental summary if the annual assessment was fully completed or not fully completed.<br><br>Summary: The Facility did not have a process in place to track and trend all dental appointments. The annual dental summary did not comment on assessments for oral cancer, and did not indicate the status of dental x-rays. There was no evidence provided to indicate that the IDT had incorporated the oral and dental health care condition, necessary supports and services, pending treatments, and risks and benefits of dental services in the annual ISP. The Monitoring Team noted that the Facility relied on different styles of annual dental summary forms; hence, there was no consistency with regards to the assessment forms. In the one example where the ISP indicated that the individual required a spin toothbrush, the annual summary did not indicate that a spin toothbrush was required. The Facility must enhance its documentation practice on the annual dental summaries, to clearly delineate screening for cancer, specific clinical issues with pathology of the teeth, and all necessary supports and services. The annual ISP must also clearly document the condition of the oral and dental health condition, risks and benefits of dental series, pending dental services, and all necessary supports and services required to enhance oral and dental hygiene.<br><br><u>Dental Emergencies</u><br>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 last five individuals on the list of individuals who had a dental emergency: | |

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| | | • Copy of all associated dental progress notes, associated with the dental emergency<br>• ISP minutes documenting the dental emergency<br>• Integrated Progress Notes (IPNs) associated with the dental emergency<br><br>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, and there were no updates since the last compliance visit.<br><br>There were 16 reported dental emergencies that occurred during the reporting period. Of the five individual cases reviewed (Individuals #742, #366, #311, #764, and #273):<br>• In zero out of five cases (0%), the dental progress notes/treatment records documented an action plan that included further monitoring parameters, and necessary follow-up for the dental emergency. There were no examples of the dentist documenting specific monitoring parameters for nursing and direct care to monitor.<br>• In zero out of five cases (0%), the IPN reflected the dental note's assessment and treatment of the dental emergency. There were no examples that the dental issue that was assessed and treated by the dentist documented as part of an IPN. The only evidence provided were copies of dental progress notes/treatment records.<br>• IPNs written by a nurse or medical provider documented the oral health care emergency that was referred to the dental office in two out of five (40%) examples.<br>• In five out of five cases (100%), the dental emergency was provided immediate clinical attention.<br>• In zero out of five cases (0%), there was evidence to support that the IDT discussed the dental emergency.<br><br>The Facility has a policy and has demonstrated a practice of addressing dental emergencies. There were no examples of the IDT being informed of dental emergencies, and the dental progress notes/treatment record did not clearly, or consistently document monitoring parameters and follow-up instructions; although not specifically required by the policy, notice to the IDT is essential so that any change of status or need for supports is addressed. The Facility did not provide examples of IPNs, by the dental office, describing the dental emergency, monitoring parameters, treatment, and follow-up instructions.<br><br><u>Oral Hygiene at the Living Area</u> | |

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| | | To assess oral hygiene efforts at the living area, the Monitoring Team requested all associated policies and procedures; dental records, IRRFs, and PMNPs for Individuals #1, #, #10, #15, and #35; and associated quality assurance assessments, specific to monitoring the provision of oral hygiene at the living area.<br><br>The Facility provided a copy of oral care policy: DSSLC Dental Services Oral Care Policy – DS 03, dated 08/1/2011. The policy dictates that all individuals served should brush or have their teeth brushed after every meal and before bedtime, but at least twice daily; and individuals should regularly floss their teeth. Review of the PNMPs and annual ISPs for Individuals #1, #, #10, #15, and #35 indicated that the Facility was not following its policy, by not specifying frequency of tooth brushing, and by not documenting the flossing needs, or associated challenges with flossing.<br><br>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.<br><br>Review of the annual ISPs, IRRFs, and PNMPs for Individuals #1, #, #10, #15, and #35 showed:<br>• Review of the current PNMP indicated that zero out of five examples (0%) indicated detailed action steps for providing oral hygiene at the living area. The PNMP, dated 5/9/2013, for Individual #5 indicated that the Individual was to use a suction toothbrush; however, the annual ISP, dated 5/9/2013 indicated that the suction toothbrush was to be discontinued, and to use a regular toothbrush. The ISP for Individual #10 did document specific about assisting with tooth brushing, but did not indicate the specific frequency, and did not address flossing issues. The PNMP for Individual #35 documented specifics about assisting with tooth brushing, but directed staff to "follow standard protocol". The Facility's protocol requires brushing to be completed after every meal, and before bed, or at least twice per day. The protocol also indicates that flossing must be done at least weekly. Any individualization of this protocol should be available to direct support staff; however, there was no evidence of documentation in PNPMs or other records available to direct support staff of other pertinent issues related to providing oral hygiene, such as specific monitoring and reporting parameters, and specific frequency of toothbrushing and flossing needs.<br>• Review of the current annual ISP indicated zero out of five examples (0%) included detailed documentation about dental issues, including current oral health care condition, and pending treatments; risks associated with dental treatments, including tooth brushing and flossing; potential limitations associated with providing oral healthcare; and necessary supports and services | |

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| | | for dental services, including oral healthcare at the living area.<br>• The Facility did not provide copies of the IRRF, and in all but one example, the annual ISP referred the reader to the IRRF for details about dental risks.<br>• The Facility did not provide documentation of assessment of staff's provision of oral healthcare at the living area. At the last compliance review the dental director informed the Monitoring Team that the Facility did not have a formal mechanism in place to routinely assess the provision of oral hygiene at the living area, and there was no evidence provided to indicate that a new process was developed.<br><br>Summary: The Facility must ensure that the PMNP documents all necessary supports and treatments, and includes specific frequency of tooth brushing, and flossing. The annual ISP must include documentation of the current oral health care condition, and pending treatments; risks associated with dental treatments, including tooth brushing and flossing; potential limitations associated with providing oral healthcare; a details about necessary supports and services for dental services, including oral healthcare at the living area. The Facility must also ensure a process that regularly assesses the efficacy of direct care staff's provision of oral healthcare at the living area.<br><br><u>Restorative Dental Treatments</u><br>The Monitoring Team requested a list of all restorative treatments completed, and not completed during the Compliance Review Period.<br><br>The Facility indicated that 5 individuals were delayed with restorative dental treatments:<br>• Individual #391 was identified as needing restorative treatment on 11/25/2013, but because there was no available day for TIVA, the Individual had been scheduled to have the restoration completed on 3/12/2014, which is a three months, three week delay because of TIVA scheduling issue.<br>• Individuals #800, #215 and #616 were delayed secondary to maladaptive behaviors and not responding to oral pre-treatment sedation.<br>• Individual #366 had missed the scheduled appointment; the reason for the missed appointment was not listed.<br><br>The Facility provided at list indicating a total of 38 individuals, of the 469 individuals who resided at the Facility (8%) received restorative treatment during the compliance review period. Of the 38 individuals, 33 (87%) were provided restorative treatment within three months after the need was identified.<br><br>Summary: When identifying a need for restorative treatment, the Facility provides restorative treatment without prolonged delay. | |

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| | | Suction Toothbrushing<br>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.<br><br>The Facility protocol on suction toothbrushing had not been updated since the previous compliance review. The protocol describes the rationale for the use of suction toothbrushing, and specific technical details of the dental toothbrushing program. However, as commented on in the last compliance report, 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 document indicating that the Facility had not developed a protocol to address these issues.<br><br>The Facility provided a list that indicated a total of 117 individuals received suction toothbrushing, and requested for the last five individuals on the list (Individuals #185, #86, #198, #32, and #134) a copy of the most recent oral health care rating scale; and copy of the Integrated Support Plan (ISP), PNMP, and IRRF. The Facility did not provide documentation for Individual #134, but instead provided documentation for Individual #24, who was outside of the scope of the document request.<br>• Zero out of five cases reviewed (0%), included documentation to support that the Facility regularly assessed efficacy of staff's administration of suction toothbrushing.<br>• The Integrated Risk Rating Form (IRRF) indicated the risks associated with suction toothbrushing in zero out of five cases reviewed (0%).<br>• The annual ISP clearly delineated the rationale for the use of suction, necessary supports for the use of suction toothbrushing, and associated risks, in zero out of five cases reviewed (0%).<br>• Physical Nutritional Management Plans (PNMPs) documented the need for suction toothbrushing, frequency for suction toothbrushing, and monitoring parameters when providing suction toothbrushing in zero out of five examples (0%).<br><br>Summary: The Facility's protocol for suction toothbrushing did not clearly delineate | |

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| | | important clinical issues, such as the monitoring of efficacy and safety of suction toothbrushing, 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 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.<br><br><u>Conclusion</u><br>The Facility maintains a well staffed dental department, and there was evidence to indicate that services provided by the dental professionals, such as annual evaluations, dental hygiene, and restorative treatments, are provided at the level of standard of care practice. The Facility, however, does not maintain necessary processes to ensure that oral hygiene issues at the living area are provided as necessary. The Facility must enhance its policies and procedures for oral hygiene and suction toothbrushing; develop and implement a process that assesses the efficacy of direct care staffs' provision of suction toothbrushing and oral hygiene at the living area; enhance the annual ISP process to ensure that all oral health related issues, including the condition of oral and dental health, necessary treatments, necessary supports and services, risks and benefits of oral and dental health treatments, and challenges associate with the provision of oral healthcare. The IRRF and PMNP must clearly delineate all necessary treatments, including frequency of treatments, associated risks, and monitoring parameters when providing oral healthcare supports. Documentation practices for the provision of emergency dental services should be more comprehensive, by including documentation of follow-up appointments, and monitoring parameters for nursing and direct care staff to follow. Because of the issues listed above, the Monitoring Team determined noncompliance with Section Q.1. | |
| Q2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; | To assess compliance issues for Section Q.2, the Monitoring Team reviewed the Facility's processes related to dental QA, programs to help reduce the need for dental related sedation, and issues related to dental anesthesia, and dental scheduling.<br><br><u>Dental Quality Assurance (QA)</u><br>At the last compliance review, 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. Review of the Facility's policy on dental quality assurance: DSSLC Dental Services Quality Assurance Policy DS-25, dated 9/11/2012, indicated that the policy had not been updated, to include a dental QA process that regularly assesses | Noncompliance |

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| | 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. | for potential adverse outcome, such as pneumonia, injuries, and maladaptive behaviors, following a.dental procedure Monitoring Team was provided pages 37 through 41 of the Facility's QAQI Council Data Meeting for 9/24/2013, and pages 32 through 36 of the 12/17/2013 QAQI Council Data Meeting. Review of the documentation indicated that the Facility had collected data for oral hygiene, broken dental appointments, timeliness of dental assessments, and the dental assessment of the assessments; however, there was no data assessing potential adverse outcomes, such as pneumonia, injuries, and maladaptive behaviors following dental services. There was no evidence to indicate the QAQI department or dental department was assessing efficacy of the provision of oral healthcare at the living area.<br><br>Data provided for review did not indicate the Facility reviewed aspiration pneumonia secondary to dental services. Also, as noted in Section L.3 of this report, the Monitoring Team raised concern over the Facility's stratification of pneumonias, and possible under reporting of aspiration pneumonia. During the Monitoring Team's meeting with the dental director, the Monitoring Team was informed that the dental department only reviews documented cases of aspiration pneumonia, and not all pneumonias; therefore, because the Facility may not be appropriately documenting all cases of aspiration pneumonia, there is a possibility that the dental department is not appropriately identifying dental cases of pneumonia, secondary to dental services.<br><br>Summary: The Monitoring Team compliments the Facility for its self-assessment of oral healthcare services, and encourages the Facility to continue with this important process. 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 outcomes, 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, when necessary.<br><br><u>Programs to Help Minimize Restraint</u><br>To assess the Facility's ability to better enable least restrictive oral health care treatment, the Monitoring Team requested the following:<br>• Alpha list of all individuals who are provided a process to help minimize the use of sedation for dental services<br>• Alpha list of all individuals who were unable to complete their dental visit/s because of challenging behaviors, and who are not currently participating in a process to help minimize the use of sedation<br>• For the first ten individuals, on the list of individuals who are provided a process to help minimize the use of sedation for dental services<br>a. Copy of program, SPECIFIC for minimizing dental sedation | |

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| | | b. Copy of program data for past six months<br>c. Copy of current ISP or addendum to ISP that documents the use of the program, and expected outcome<br>d. Copy of scheduled opportunities for the program<br>e. Copy of completed opportunities for the program<br><br>The Facility provided a list called dental audit listing/desensitization information, revised 1/7/2014, that listed approximately 500 individuals, and included items such as audit date, desensitization plan date; Skill Acquisition Plan (SAP), "REF date", and last annual. The Monitoring Team could not determine how to use or interpret the list; hence, the Monitoring Team was unable to determine the number of individuals at the Facility who require a program to reduce the need for dental sedation, and who was actually provided a plan to reduce the need for dental sedation.<br><br>The Monitoring Team was provided dental desensitization skill acquisition plans – Dental chair documents for five individuals; however, since the Facility did not provide a list interpretable by the Monitoring Team of the individuals who were provided a program to reduce the need for dental sedation, the Monitoring Team could not determined if the examples provided were for the first ten individuals on the list.<br><br>Review of the data, summary of data, graphs and ISP specific for the program to help reduce the need for dental sedation, provided for Individuals #170, #474. #430, #534, #204, #123, #169, #2, #669, and #1, showed:<br>• There was documented evidence that a specific program was developed in ten out of ten examples (100%).<br>• Data was collected, as delineated by the program, in ten out of ten examples (100%).<br>• Data was graphically represented in one out of ten examples (10%).<br>• The ISP or addendum to the ISP made reference to the program in six out of ten examples (100%).<br>• There was evidence that the program was provided at least two times per month in ten out of ten examples (100%).<br><br>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.<br><br>Compliance will require additional improvements in the following areas:<br>• There must be an accurate accounting programs to help minimize the use of sedation. For example, the Facility must effectively track all individuals who | |

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| | | have been assessed for a program, have not been assessed, as well as outcome data that will help establish efficacy of the program.<br>• Ensure that all individuals who receive sedation or restraint for dental care have been assessed for a program to help minimize the use of sedation. The Monitoring Team could not determine, by review of the documents provided, if this had or had not occurred.<br>• Ensure that training opportunities occur at a frequency that benefits the individuals. By review of the documents, the Monitoring Team could not determine what frequency of program implementation would be beneficial to the individual. This would vary depending on the individual and the specific program and should be determined by the IDT but must be frequent enough to show effect.<br><br><u>Dental Schedule</u><br>The Facility provided a copy of its dental schedule, which is a handwritten log. The Facility had not implemented a process to ensure effective tracking of all dental services. The Monitoring Team noted that the handwritten dental schedule was very difficult to interpret by the Monitoring Team.<br><br>The Facility provided a copy of its 9/24/2013 and 12/27/2013 QAQI Data Meeting minutes, and although the minutes included data for missed dental appointments, there was no breakdown of the specific reason for the missed appointments, such as an unexpected hospitalization, illness, family visit, maladaptive behavior; or specific staff related issue, communication failure, transportation failure, and staff shortage.<br><br>Summary: The Monitoring Team determined that the Facility had yet to develop an effective mechanism to track and trend all dental services for individuals served by the dental office, and did not adequately track and trend missed appointments. The Monitoring Team strongly recommends that the Facility enhance its ability to track and trend dental scheduling and services provided that are related to dental services, such as dental examinations, dental imagine, dental hygiene, and restorative treatments.<br><br><u>General Anesthesia (intubation)</u><br>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.<br><br>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. | |

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| | | Oral Sedation<br>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.<br><br>Total Intravenous Anesthesia (TIVA)<br>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.<br><br>The Monitoring Team reviewed the DSSLC policy for Dental Services IV Sedation DS-24, dated 8/1/2011. Following the document review for TIVA, the Monitoring Team determined that the Facility was following its procedure for intravenous sedation for dental services.<br><br>The Monitoring Team reviewed the Facility's standardized orders for TIVA, and following review of the documents provided for TIVA, the Monitoring Team determined that the Facility was appropriately implementing the standardized orders.<br><br>The Facility provided a copy of the consent form for TIVA, and the Monitoring Team noted that the consent form list some of the common and serious side effects associated with pharmacological products used during TIVA.<br><br>The Facility provided copies of its standardized checklist that are used during and following TIVA, that assess clinical activities, such as level of sedation, oxygen saturation, and post TIVA recovery. Following document review for TIVA, the Monitoring Team determined that the Facility consistently utilized standardized clinical assessment forms for TIVA services.<br><br>The Facility provided a document that indicated that 191 individuals required dental treatments under TIVA for all dental services. The dental director provided a statement documenting that all individuals at the Facility are provided TIVA for all necessary dental examinations, oral hygiene twice per year, and for restorative treatments, unless an unforeseen circumstance, such as an individual was hospitalized and missed the TIVA appointment.<br><br>Review of TIVA records for the first five individuals on the list of individuals who require TIVA is as following (individuals #705, #587, #474, #445, #633) showed: | |

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| | | • In five out of five cases (100%), anesthesiology records were complete, and documented all necessary monitoring parameters.<br>• 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.<br>• 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.<br>• In five out of five cases (100%), the nurse performed, and documented pre-sedation assessment.<br>• In zero out of five cases (0%), the dental office provided post-sedation monitoring orders, such as monitoring, and reporting parameters, to be completed at the living area, by direct care staff. The Monitoring Team noted that the standardized form used by direct care staff to communicate post-monitoring effects, was blank for each example.<br><br>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.<br><br>The Monitoring Team continues to be 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. Because the effects of anesthesia are known to continue beyond assessment of a REACT score of 10, such as occasional unsteady gain, possible behavioral issues secondary to the procedures, and continued risk of aspiration, the Monitoring Team recommends that the Facility ensure that the post anesthesia monitoring form for direct care staff is completed, and provided for review at the next compliance visit. It should be noted that the Monitoring Team was informed that continued monitoring of individuals did occur at the living area for an additional 24 hours; however, the Monitoring Team was not provided with supporting documentation for the examples reviewed.<br><br>Conclusion:<br>The Monitoring Team recognizes that DSSLC provides adequate TIVA resources, and that the Facility provides clinical monitoring before, during, and post sedation. The Facility did not adopt a mechanism to efficiently track and trend dental services, or to maintain an effective dental schedule. The Facility has an effective system for evaluating the quality of dental treatments, but did not have a process to monitor and assess possible adverse outcomes secondary to dental services, such as exacerbation of maladaptive behaviors, injuries, or pneumonia. The Facility also did not provide evidence that it stratifies the reasons for missed appointments, such as illness, other medical appointments, or hospitalizations, maladaptive behaviors, and system issues such as staff | |

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| | | shortages, communication issues, and lack of transportation. Because of these issues, the Monitoring Team determined noncompliance with Section Q.2. | |

| SECTION R: Communication | |
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| Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self Assessment 12/27/13<br>2. DSSLC Action Plan 12/5/13<br>3. Facility Section R Presentation Book<br>4. Communication Services Policy (CMGMT-23, rev 10/23/13)<br>5. Speech Department Handbook rev: October 2013<br>6. Record Reviews of Individuals:<br>• Sample R.1: Individuals #259, #273, #283, #296, #339, #478, #595, #684, #707, and #779<br>• Sample R.2: Individuals #151, #591, and #800<br>• Sample R.3: Individuals #94, #134, #622, #726, and #783<br>• Sample R.4: Individuals #273, #277, #283, #336, #339, #469, #499, and #540<br>• Sample R.5: Individuals #259, #478, #595, and #684<br>7. Communication Master Plan<br>8. List of current SLPs, caseloads and ratios<br>9. Copies of each SLP's current license and ASHA certification<br>10. Continuing education and training completed by the SLPs in the past 12 months<br>11. Facility list of new admissions since the last review<br>12. Tracking log of SLP assessments completed since the last review<br>13. Facility list of individuals with severe language deficits<br>14. Facility list of individuals with PBSPs and replacement behaviors related to communication<br>15. PBSP minutes and attendance rosters for the past six months<br>16. Facility list of individuals with Alternative and Augmentative communication (AAC) devices<br>17. Facility AAC screening forms<br>18. Facility AAC-related database reports/spreadsheets<br>19. Facility list of general common area AAC devices<br>20. Facility list of individuals receiving direct communication-related intervention plans<br>**People Interviewed:**<br>1. Becky Nurre CCC-SLP Director of Communication Services<br>2. Paula Horn PT Director of Habilitation Services<br>3. Nine DCPs (Garden Ridge, Cedar Falls, and Eastfield)<br>**Meeting Attended/Observations:**<br>4. Mealtimes and Transitions- Garden Ridge, Cedar Falls, Houston Park and Eastfield, |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section R, dated 12/27/13 and Action Plan dated 12/5/13. 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.<br><br>Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement, |

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| | the Facility found it was in compliance with Provision R.1 and not in compliance with R.2 through R.4. This was consistent with the Monitoring Team's findings.<br><br>For Section R in conducting its self-assessment:<br>The self-assessment was significantly improved. There were very clear and relevant activities that consisted of monitoring as well as the intake of data relevant to assessments, staff trained, and participation by staff in plan related activities (e.g., ISP). All of these were clearly linked to past reports. Activities in the Self-assessment correlated well to previous recommendations made by the Monitoring Team and reflected significant improvements<br><br>Overall, the 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:**<br>Overall, Speech Assessments showed significant improvement regarding comprehensiveness. DSSLC did a much better job identifying programs to help improve expressive and receptive language. Although programs may have shown improvement, implementation of communication programs remained low and staff knowledge of how to form effective communication with the individuals remained not evident at the home level.<br><br>**Provision R.1:** This provision was determined to be in substantial compliance. DSSLC was at full capacity with regards to Speech Pathologists and had recently opened another position for a Speech Therapy Assistant. All Therapists were board certified and licensed to practice in the state of Texas. All Therapists had evidence of participating in continuing education that was relevant to the field of practice.<br><br>**Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having decreased communication did not have their plans implemented as written or throughout the day when opportunities for increased communication were presented.<br><br>**Provision R.3:** This provision was determined to be not in compliance. Integration into the ISP had shown improvement as evidenced primarily by improved comprehensiveness of the PNMP. Concerns were noted however regarding AAC being readily available and utilized within the home environment. Additionally, direct treatment plans did not provide clear measurable goals in which success could be determined.<br><br>**Provision R.4:** This provision was determined to be not in compliance. DSSLC did not have a comprehensive monitoring system that covered the presence and condition of the device, implementation of the device, as well as SLP participation in care. DSSLC had recently developed a system that had the needed guidelines but the process was in its infancy and did not have sufficient and consistent data to determine compliance at this time. |

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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:<br><br>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.<br><br>Sample R.2: Consisted of five Individuals receiving direct speech services.<br><br>Sample R.3: Consisted of five Individuals with a PBSP and communication deficits.<br><br>Sample R.4: Consisted of eight Individuals from R.1 above with AAC systems<br><br>Sample R.5: Consisted of four individuals from R.1 who received indirect Speech Services/Supports.<br><br>**Staffing**<br>The Facility did provide an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. In addition to DSSLC being fully staffed, there was evidence of improved presence during the annual ISP meetings.<br><br>As of this review, DSSLC was fully staffed with the director, six staff SLPs and one Speech Pathology Assistant (SPA). The SPA was to help provide modeling as well as assist in the development of plans and programs and assist with the monitoring process. The current staffing allowed for a caseload as listed below:<br>• Sandra Leung: 82 Individuals<br>• Sherri Tuggle: 66 Individuals<br>• Benette Gaskill: 72 Individuals<br>• Linsay Lilly: 70 Individuals<br>• Elizabeth Evans: 79 Individuals<br>• Mimi Zatout: 96 Individuals<br><br>The individual SLP caseloads were divided at a time when there were seven units resulting in 4 SLPs with one unit each and 2 SLPs with 1.5 units each. The seventh SLP's caseload is all of the treatments that are to be performed by the SLP Assistant due to the laws in Texas that govern how an SLP Assistant is allowed to provide treatment. The seventh SLP was also partially responsible for portions of Section R in the Settlement Agreement.<br><br>Per the Director of Communication Services, this way of dividing up the caseloads was currently meeting their needs regarding the completion of assessments, providing active | Substantial Compliance |

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| | | treatment, and completing monitoring of indirect communication services/supports.<br><br>**Qualifications:**<br>Seven of seven positions for SLPs (100%) for which documents were provided to the Monitoring Team were filled by licensed SLPs.<br>• Seven of seven SLPs (100%) were licensed to practice in the state of Texas.<br>• Seven of seven SLPs (100%) had evidence of ASHA certification.<br><br>**Continuing Education:**<br>Based on a review of continuing education completed in the last 12 months, seven of seven 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:<br>• AAC and Autism<br>• The Tablet Revolution and AAC<br><br>**Facility Policy**<br>A local policy/process did exist that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services.<br><br>DSSLC had a localized Communication Services Policy (CMGMT-23, rev 10/23/13). The policy contained the following components:<br>• Roles and responsibilities of the SLPs (meeting attendance, staff training etc.).<br>• Timelines for completion of new admission assessments<br>• Criteria for providing an update<br>• Outlines assessment schedule.<br>• Frequency of assessments/updates.<br><br>Since the previous compliance visit, DSSLC had added the following components to the policy and/or procedures:<br>• Addressing a process for effectiveness monitoring by the SLP.<br>• Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution.<br>• Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication<br>• Methods of tracking progress and documentation standards related to intervention plans. | |

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<tr><td>R2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.</td><td><u>Assessment Plan:</u><br>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.<br><br>During the last compliance review, DSSLC provided comprehensive assessments to all individuals during admission. Per interview with the Director of Communication Services, this practice was in the process of being revised and individuals who were admitted would only receive a screening by the SLP that would assist the therapist in determining if a more comprehensive assessment was needed. As of this review, this new practice had not yet been implemented and will need to be reviewed at the next compliance visit.<br><br>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 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 December 2014. The Master Plan for assessments was as follows:<br><br>
<table>
<tr><th>Priority Group</th><th>Description</th><th>Projected Completion Date</th></tr>
<tr><td>1</td><td>Individuals with a Care Code for Speech of 3 or 4 and are the most dependent on others for their wants and needs as well as a pilot project with the men who live in apartment 509C; the assessments for the individuals in this group are almost completed.</td><td>12/31/2012</td></tr>
<tr><td>2</td><td>Individuals with a Care Code for Speech of 3 or 4 who are designated as "high" risk for challenging behavior and/or who have a PBSP with a replacement behavior or behavior to increase that involves communication.</td><td>12/31/2012</td></tr>
<tr><td>3</td><td>Individuals with a Care Code for Speech of 3 or 4 who have a PBSP with a replacement behavior or behavior to increase that does not involve communication</td><td>12/31/2013</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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| 4 | Individuals with a Care Code for Speech of 3 or 4 who do not have a PBSP | 12/31/2014 |
| 5 | Individuals with a Care Code for Speech of 1 or 2 | 12/31/2015 |

Other Times Communication Assessments were to be completed:

Upon Admission to facility
- Within 30 days

Transition/expected transition to the community or other placement.
- Per schedule

If receiving direct or indirect services:
- Re-assess annually

If receiving neither direct nor indirect services:
- Re-assess/screen:
  - at the recommendation of the IDT
  - significant changes/suspected changes in an individual's communication skills (gain or loss of skills)
  - or at the discretion of the SLP (not to exceed five years)
- Screen every (5) years after a full evaluation of everyone in the entire priority group is completed

As of this review:
- 109/109 priority 1 Assessments completed; 100% of priority 1
- 135/135 of priority 2 Assessments completed; 100% of priority 2
- 41/41 of priority 3 Assessments completed; 100% of priority 3
- 29/100 of priority 4 Assessments completed; 29% of priority 4
- 37/92 of priority 5 Assessments completed; 40% of priority 5

Overall, the Facility had completed comprehensive assessments for priority groups 1, 2, and 3. The plan is to complete the remaining comprehensive assessments for groups 4 and 5 by 12/31/14.

**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.

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| | | Seven of seven individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission.<br><br>For 10 of 10 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP.<br><br>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.<br><br>**Communication Assessment:**<br>Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows:<br>• Thirteen of 15 individuals' Communication assessments (87%) were signed and dated by the clinician upon completion of the written report;<br>• Thirteen of 15 individuals' Communication assessments (87%) were dated as completed at least 10 working days prior to the annual ISP;<br>• Thirteen of 15 individuals' Communication assessments (87%) included diagnoses and relevance of impact on communication;<br>• Thirteen of 15 individuals' Communication assessments (87%) included individual preferences, strengths, and needs<br>• Thirteen of 15 individuals' Communication assessments (87%) included medical history and relevance to communication<br>• Four of 15 individuals' Communication assessments (27%) listed medications and discussed side effects relevant to communication. It should be noted that four out of four assessments (100%) completed since the format revision in October 2013 contained this component.<br>• Thirteen of 15 individuals' Communication assessments (87%) provided documentation of how the individual's communication abilities impacted his/her risk levels;<br>• Thirteen of 15 individuals' Communication assessments (87%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day;<br>• Thirteen of 15 individuals' Communication assessments (87%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work);<br>• Thirteen of 15 individuals' Communication assessments (87%) 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 | |

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| | | necessary changes as required for individuals who did not communicate verbally;<br>• Thirteen of 15 individuals' Communication assessments (87%) included discussion of the expansion of the individuals' current abilities.<br>• Thirteen of 15 individuals' Communication assessments (87%) provided a discussion of the individuals' potential to develop new communication skills;<br>• Thirteen of 15 individuals' Communication assessments (87%) 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.<br>• Four of 15 individuals' Communication assessments (27%) offered a comparative analysis of health and functional status from the previous year. It should be noted that four out of four assessments (100%) completed since the format revision in October 2013 contained this component.<br>• Thirteen of 15 individuals' Communication assessments (87%) gave a comparative analysis of current communication function with previous assessments.<br>• Thirteen of 15 individuals' Communication assessments (87%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it.<br>• Thirteen of 15 individuals' Communication assessment (87%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff;<br>• Thirteen of 15 individuals' Communication assessments (87%) had a reassessment schedule;<br>• Thirteen of the 15 individuals' Communication assessments (87%) supplied a monitoring schedule. While the monitoring schedule was not recommended as part of the assessment, a standard schedule was in place that outlined the frequency and therefore this was considered appropriate in meeting this component.<br>• Thirteen of 15 individuals' Communication assessments (87%) 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.<br>• Thirteen of 15 individuals' Communication assessments (87%) made a recommendation about the appropriateness for community transition.<br>• Thirteen of 15 individuals' Communication assessments (87%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day.<br><br>In order to move towards substantial compliance, DSSLC must ensure that the | |

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| | | components listed above are consistently integrated into the Communication Assessment. The new format which was initiated in October 2013 appears to have addressed the missing components but the sample in which these were noted was small and will need to be reviewed during the next compliance visit to ensure full implementation of the new assessment.<br><br>**<u>SLP and Psychology Collaboration:</u>**<br>Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs), the following was noted:<br>• Five of five 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.<br>• For four of five individuals (80%) communication strategies identified in the assessment were included in the PBSP.<br>• For five of five individuals (100%) communication strategies identified in the assessment were included in the ISP.<br><br>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 12 of 15 (80%) meetings.<br><br>The SLPs and behavioral services staff 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.<br><br>Per the Director of Communication Services, PBSPs are not approved unless the following indicators are present.<br>• There is evidence of collaboration between behavioral services and the SLP regarding PBSPs that have communication as a significant component of the PBSP..<br>• There is collaboration between behavioral services and SLP in developing a skill acquisition plan (SAP).<br>• There is collaboration between behavioral services and the SLP in providing Competency based Training (CBT) in the form of a SAP to the individual and staff.<br>• Behavioral services staff and the SLP have a plan for regular monitoring of the program established as part of the PBSP. | |

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| R3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings. | **Integration of Communication in the ISP**<br>Based on review of the ISPs for individuals in Samples R.1 and R.2 the following was noted:<br>• In 15 of 15 ISPs reviewed (100%) 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 IDT provided adequate justification.<br>• Fifteen of fifteen ISPs reviewed (100%) 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.<br>• Communication Dictionaries for 15 of 15 individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs.<br>• Fifteen of 15 ISPs reviewed (100%) included how communication interventions were to be integrated into the individual's daily routine. This was included as part of the PNMP and included as part of the Communication assessment.<br>• Eleven of 15 ISPs reviewed (73%) contained skill acquisition programs to promote functional communication.<br>• Eleven of 11 ISPs reviewed (100%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP.<br><br>**Development And Implementation Of Functional Individual-Specific Assistive Communication Systems**<br>For three of three 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.<br><br>Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following:<br>• Four of eight observations (50%) found AAC devices present in each observed setting and readily available to the individual.<br>• AAC systems for two of eight individuals (25%) were noted to be in use in each observed setting.<br>• AAC systems for six of eight individuals (75%) were portable.<br>• AAC systems for eight of eight individuals (100%) were functional.<br>• For six of eight individuals (75%), staff instructions/skill acquisition plans related to the AAC system were available.<br><br>The majority of the assessments for the individuals in Samples R.1 and R.4 provided an | Noncompliance |

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| | | adequate assessment of the individual's potential for AAC use. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use in settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration, or massage.<br><br>**General Use AAC Devices:**<br>Observations were completed in six homes and to determine the presence and use of general AAC devices. Findings included the following:<br>• Six of six homes (100%) had general use AAC devices present in the common areas.<br>• In four of six homes and other environments (66%), general use AAC devices were operational.<br>• Four of the six general use AAC devices (67%) noted contained clear directives on how staff should use these devices.<br>• Six of six general use AAC devices (100%) noted had a clear function within that setting/situation.<br>• Zero of six 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.<br><br>**Direct Communication Interventions**<br>Review of the individuals' records from Sample R.2 showed the following:<br>• Three of three 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.<br>• For three of three individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale.<br>• For zero of three individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. For example, Individual #151's goal stated that the individual would participate in communication therapy to improve functional skills but provided no information what success would look like when achieved.<br>• For three of three individuals (100%), information was present regarding whether the individual showed progress with the stated goal. Since the goal was not measurable, the Monitoring Team reviewed the baseline information and subsequent monthly notes to determine if progress was made and documented.<br>• For zero of three individuals (0%), a description was found of the benefit of the | |

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| | | device and/or goal to the individual. There was no evidence that the therapist reported how the goal would support communication for the individual in their daily activities and why the items worked on in therapy were meaningful to the Individual.<br>• For three of three individuals (100%), a report was found regarding the consistency of implementation.<br>• For three of three individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress.<br>• No individuals were discharged from direct treatment in the sample. Therefore, the Monitoring Team could not assess whether termination of the intervention would be well justified and clearly documented in a timely manner. .<br>• For three of three individuals (100%) progress notes occurred at a minimum monthly.<br><br>Information provided to the Monitoring Team in response to the request for a "list of individuals receiving direct speech therapy" was inaccurate, as two individuals who were on the list were not receiving direct therapy; therefore, the sample drawn was less than expected and these metrics were unable to be fully assessed for compliance. It is recommended that DSSLC review the process for providing this information and ensure its accuracy for future reviews.<br><br>**Indirect Communication Supports:**<br>Programs for individuals in Sample R.5 who received indirect communication supports were reviewed and found:<br>• Four of four 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.<br>• For four of four individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale.<br><br>For eight of eight individuals in Sample R.4 (100%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures.<br><br>Zero of four individuals (0%) receiving indirect Speech Services (Sample R.5) were provided with comprehensive progress notes that contained each of the indicators listed below.<br>• Quarterly documentation for two of four individuals (50%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. Review consisted of only stating that the service was | |

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| | | provided, a general observation and offered minimal information regarding effectiveness of supports in meeting desired outcomes.<br>• Quarterly documentation for zero of four individuals (0%) identified the benefit of device and/or goal(s).<br>• Quarterly documentation for zero of four individuals (0%) identified consistency of implementation.<br>• Quarterly documentation for zero of four individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress.<br><br>**Staff Interviews**<br>Four of nine staff interviewed (44%) were knowledgeable of the individual and their communication related programs; direct support professionals had difficulty with the following questions<br>• Stating whether the individual had an AAC system.<br>• Whether there was a communication program.<br>• Describing the communication program goal.<br>• Described the schedule for implementation of the communication program.<br>• Identifying how communication skills in the program were addressed throughout the day.<br><br>**Competency-Based Training and Performance Check-offs:**<br>Based on review of the NEO training curriculum, and individualized training, DSSLC did develop comprehensive competency based training regarding communication services.<br>• The training materials reviewed did address all the appropriate content areas listed below:<br>o Methods to enhance communication<br>o Implementation of programs<br>o Benefits and use of AAC<br>o Identification of non-verbal means of communication.<br><br>Per the Director of Speech, increased staffing has resulted in increased ability to model AAC and monitor staff implementation. The increased monitoring has been noted through the review of the AAC monitoring forms but there remains a significant lack of implementation and follow up to the completed monitors.<br><br>DSSLC had begun providing some degree of monitoring of devices to ensure they were in working order and available, but this process was still inconsistent. Per review of the monitoring sheets, many times items were missing or were nonfunctional but there was | |

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| | | no evidence of replacement or timely repair. Examples included Individuals #326 and #362 whose AAC/EC devices were missing from 11/1/13 to 12/12/13 with no evidence of replacement.<br><br>In order to move towards substantial compliance, DSSLC must develop a consistent monitoring process that will ensure all devices are working properly, are available and staff are provided consistent modeling on how to use the devices.<br><br>Two hundred and twelve of 212 new employees between 8/1/13 and 12/31/13 (100%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review.<br><br>**Individual-Specific Competency-Based Training**<br>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 three individuals in Sample R.4 had received training related to Communication SAPs and/or program.<br><br>Three of three (100%) individual's staff assigned had completed competency check-offs regarding the individuals' communication programs.<br><br>The Speech Therapist was responsible for training staff and therefore Staff responsible for training other staff was competent in training the specialized components (i.e., non-foundational skills) of the individuals' communication plans prior to training others. Staff responsible for training was the Speech Therapy. | |
| 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 | **Policy and Procedure**<br>A Facility policy and/or procedures did 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 include the essential components related to monitoring. Included in the process/policy were clear guidelines regarding the frequency in which the presence, working condition was to be monitored by the Speech Technician.<br><br>The process was as follows:<br>• Equipment Monitoring would be done routinely for each individual who has equipment from the Speech Department, regardless of type of service provided. Staff from the Speech Department, Unit Staff and Staff from Active Treatment may complete the tracking and monitoring of equipment.<br>• Schedule for shared equipment: Speech Department will monitor monthly and Unit and Programming would monitor weekly. | Noncompliance |

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| | available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually. | • Schedule for Individual equipment: Speech Department will monitor periodically and Unit and Programming would monitor weekly.<br>• All information would be entered in to the Speech Data Base.<br><br>In addition to the monitoring of working condition and presence 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 and/or received indirect SLP treatment.<br><br>An improvement noted was that guidelines/procedures had been developed that formalized all monitoring processes.<br><br>The concern as mentioned above in R.3 was that while there were now guidelines, implementation was not yet at the level needed to ensure equipment was present and in working order on a consistent basis. It should be noted that this was a new process and still in its infancy and the Monitoring Team looks forward to seeing the process once fully implemented during subsequent visits.<br><br>**Monitoring of Implementation of Communication Supports**<br>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 found:<br>• For four of four individuals (100%), monitoring of communication supports was outlined in the assessment. While the assessment did not clearly indicate the level of monitoring, this was noted as part of the new guidelines developed for effectiveness monitoring and compliance monitoring.<br>• For zero of four individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. This was a new process so the Monitoring Team was unable to determine if the monitors occurred as specified by policy due to DSSLC at this time being unable to pull the needed data.<br><br>AAC monitoring was conducted that focused on presence and working condition, but this monitoring was not consistently occurring at this time. Effectiveness monitoring of AAC was to occur quarterly but there was limited evidence that this consistently occurred. As stated above, this process was still new and not yet fully implemented to the satisfaction of DSSLC.<br><br>Six of 10 individuals from Sample R.1 (60%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. While the QIDP reviewed the supports, the information contained within the review was | |

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| | | lacking detail regarding if the individual achieved progress and if the supports remained appropriate This represented an improvement of 40% since the previous review. | |

| SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs | |
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| Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment (12/27/2013)<br>2. DSSLC Action Plan (12/05/2013)<br>3. DSSLC Presentation Book for Section S (1/17/2014)<br>4. Documents that were used as part of the document review process included the following.<br>• For Provision S.1, ISPs, related assessments, and SAPs were reviewed for Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br>• For Provision S.1, the content and composition of SAPs were reviewed for Individuals #4, #54, #131, #206, #208, #238, #295, #311, #353, #368, #506, #517, #565, #612, #617, #631, #632, #637, #638, #650, #690, #734, #753, and #774.<br>• For Provision S.2, the facility tracking spreadsheets for assessment report submissions was reviewed<br>• For Provision S.3.a, SAPs and data collection forms were reviewed for Individuals #24, #34, #53, #87, #88, #141, #188, #189, #195, #209, #313, #332, #362, #417, #485, #608, #705, #706, #772, and #774.<br>• For Provision S.3.b, Facility summary data for community outings and SAP training sessions were reviewed.<br>**People Interviewed:**<br>1. Trent Lewis – Vocational Services Director<br>2. Pung Nelson – Director of Life Skills Program<br>3. Randy Spence, MS – Director of Behavior Services<br>4. Laura Dittlinger-Harper, BCBA - Consultant<br>5. Approximately 25 direct support professionals in the following residences: 502b, 502c, 502d, 505c, 506c, 507a, 508a, 508c, 512d, 515a, 515b, 515c, 515d, 522a, 522a, 524a, 524d, 527b, and 528b.<br>**Meetings Attended/Observations:**<br>1. ISP meeting for Individual #791<br>2. Observations were conducted in the following residences: 502b, 502c, 502d, 505c, 506c, 507a, 508a, 508c, 512d, 515a, 515b, 515c, 515d, 522a, 522a, 524a, 524d, 527b, and 528b. |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section S. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.<br><br>For Section S, in conducting its self-assessment, the Facility:<br>▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed |

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| | monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff:<br>o The monitoring/audit tools the Facility used to conduct its self-assessment included: the SAP/SLP (Communication) Audit, the Program Observation Drill, the Timeliness of Assessment Audit, the Assessment Review, and the Skill Acquisition Program Monthly Review.<br>o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.<br>o The monitoring tools included adequate methodologies, such as observations of staff performance, monthly and quarterly review of assessments and SAPs, review by multiple disciplines, such as QA and the Section S BCBA.<br>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). This sample sizes were adequate to consider them representative samples.<br>o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results.<br>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).<br>o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools.<br>▪ Used other relevant data sources, such as the tracking database for the timeliness of assessment reports.<br>▪ The Facility did not consistently present data in a meaningful way. Specifically, the Facility's Self Assessment:<br>o Did not present findings consistently based on specific, measurable indicators. For example, tracking data of training and employment activities did not consistently use the same terminology, making it difficult to determine actual training and employment trends.<br>o Did not consistently measure the quality as well as presence of items.<br>o Distinguished data collected by the QA Department versus the program/discipline.<br>▪ The Facility rated itself as being in compliance with the following provisions of Section S: Provision S.3.b. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with no provisions. The Facility was accurate in stating that records reflected substantial SAP implementation in the community, an element of Provision S.3.b. The Monitoring Team found, however, that amongst other issues, the SAPs often lacked support from assessments, lacked key components, and lacked data concerning the quality and consistency of implementation.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>▪ Actions were reported as primarily Complete or In Process.<br>▪ The Facility data identified areas of need/improvement. The Action Plans consistently cited |

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| | evidence to support the Action Steps, but did not frequently provide additional data or analysis.<br>▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. In most cases, the Action Plans presented actions that were to be performed, such as retraining staff on active treatment, but did not address the issue of ensuring that the training produced increases in staff knowledge or performance. |
| | **Summary of Monitor's Assessment:**<br>Observations, interviews, and record reviews were conducted on-site at DSSLC from 1/13/2014 through 1/17/2014. 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 invested considerable effort in improving the quality of services addressed by Section S of the Settlement Agreement. As a result, in some areas substantive progress had been achieved. In other areas, however, no progress was noted and at times, the Facility had regressed.<br><br>Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved.<br>• Skill acquisition plans better reflected individual preferences.<br>• Components of skill acquisition plans had improved modestly.<br>• The percentage of individuals observed during monitoring to be functionally engaged had improved.<br>• The percentage of assessment reports prepared for ISPs had improved.<br>• The Facility continued to provide abundant leisure and training opportunities in the community.<br><br>Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas.<br>• Almost two thirds of the skill acquisition plans reviewed by the Monitoring Team were not based upon adequate assessments or lacked adequate discussion in the ISP report.<br>• A substantial number of skill acquisition programs continued to lack essential components, such as adequate behavioral objectives, sufficient trials, specific instructions for providing teaching, and plans for maintenance and generalization.<br>• Numerous data collection forms for skill acquisition programs reflected poor compliance with training schedules, missing data, and data recording practices that did not match instructions in the skill acquisition program.<br><br>Based upon interviews, observations, record reviews, and other material, it was evident that the Facility had achieved some progress. This information did not support finding the Facility in substantial compliance with Section S of the Settlement Agreement. |

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<tr><td></td><td>six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>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, documentation included very few examples of 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. During the July 2013 site visit, documentation continued to reflect that DSSLC had not fully developed and implemented a process for providing comprehensive assessment or using assessment findings.<br><br><u>Current Site Visit</u><br>During the current site visit, the Facility provided one recent ISP with associated SAPs from 14 residences. From these, the first SAP presented in the submitted documents for each ISP was selected as the sample. This allowed for a sample of 14 SAPs. The individuals for whom SAPs were reviewed included Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774.<br><br><u>Use of Assessment Information in Planning Skill Acquisition</u><br>Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.<br><br>The table below reflects the status of assessments in relation to the sampled SAPs. Information in the table reflects modest improvement in relation to the use of assessments.<br><br>
<table>
<tr><th></th><th>3/2010</th><th>7/2013</th><th>1/2014</th></tr>
<tr><td>Skill acquisition plans are implemented to address needs identified in:</td><td></td><td></td><td></td></tr>
<tr><td>ISP</td><td>0%</td><td>25%</td><td>29%</td></tr>
<tr><td>Adaptive skill or habilitative assessment</td><td>0%</td><td>25%</td><td>36%</td></tr>
<tr><td>Psychological assessment</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Skill acquisition plans are chosen in an individualized manner.</td><td>0%</td><td>0%</td><td>29%</td></tr>
<tr><td>Skill acquisition plans are related to the individual's preferences.</td><td>0%</td><td>0%</td><td>21%</td></tr>
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<br>Based upon the information submitted by the Facility, it was not evident that assessments were used in the development of SAPs for the majority of individuals living at the Facility. There was some indication, however, of improvement in comparison with previous site visits.</td><td></td></tr>
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| | | • ISPs for four of 14 SAPs (29%) reflected evidence to support the reviewed SAP.<br>• Functional Skill Assessments (FSAs) for five of 14 SAPs (36%) reflected evidence to support the reviewed SAP. Records did reflect that each individual had been provided with skill assessment by means of the FSA. In 64% of the reviewed SAPs, however, it was not evident that the FSA had been effectively used in the development of skill acquisition programs<br><br>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 SFA 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.<br><br>Of the 14 individuals included in the sample, all 14 (100%) had been provided a formal assessment of adaptive skills. These assessments were conducted using a standardized instrument, typically the Vineland Adaptive Behavior Scales – Second Edition, and were presented in reports developed for the Behavior Services department. In none of the 14 records (0%) was there indication that the formal assessment of adaptive skills was used in formulating teaching programs.<br><br>All individuals included in the sample had been provided a preference assessment using the Preferences and Strengths Inventory (PSI). This tool provides a subjective measure that relies upon self-report and staff observation regarding what the individual prefers in relation to residence, leisure, employment, diet, and numerous other areas. A large number of individuals living at the Facility experienced substantial deficits in communication skills. It was not evident from the preference assessments that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore, it was not evident that the Facility had made use of other means to identify personal preference with people experiencing communication limitations, such as systematic observations by neutral staff or providing the individual systematic opportunities to select or indicate preferred items. Rather, the preference assessments for individuals with limited communication routinely consisted of general, anecdotal statements of undocumented origin that could not be verified or validated.<br><br>Despite the weaknesses in the assessment of individual preferences, there was some indication that the Facility had attempted to use PSI findings in the development of SAPs. In three of the 14 records in the sample (21%), both the ISP and the SAP reflected information from the PSI.<br><br>Based upon the available information, despite some improvement, there was little to indicate that the Facility systematically and comprehensively integrated assessments into the development of Skill Acquisition Programs. | |

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| | | Teaching New Skills<br>In order to assess the components of the SAPs, a total of 24 skill acquisition programs were reviewed. This sample included the 14 SAPs presented above, as well as 10 SAPs included in the Section S Presentation Book prepared by the Facility. The individuals for whom SAPs were reviewed included Individuals #4, #54, #131, #206, #208, #238, #295, #311, #353, #368, #506, #517, #565, #612, #617, #631, #632, #637, #638, #650, #690, #734, #753, and #774. | |

| | 03/2010 | 7/2013 | 1/2014 |
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| Plan requiring a task analysis | 0% | 79% | 67% |
| Percentage of plans requiring a task analysis that reflected a task analysis | 0% | 0% | 0% |
| Behavioral objective(s) | 0% | 36% | 42% |
| Operational definitions of target behavior | 0% | 36% | 67% |
| Description of teaching conditions | 0% | 21% | 46% |
| Schedule of implementation plans for sufficient trials for learning to occur | 0% | 7% | 8% |
| Relevant discriminative stimuli | 0% | 79% | 67% |
| Specific instructions | 0% | 21% | 58% |
| Opportunity for the target behavior to occur | 0% | 93% | 83% |
| Specific consequences for correct response | 100% | 29% | 79% |
| Specific consequences for incorrect response | 0% | 64% | 83% |
| Plan for maintenance and generalization that includes assessment and measurement methodology | 0% | 43% | 17% |
| Documentation methodology | 0% | 29% | 75% |

In seven of the 12 areas included in the review (58%), there was improvement of at least five percent. Not all of these areas of improvement reflected ratings that approached the criteria necessary for substantial compliance. Nevertheless, these ratings suggested a meaningful effort on the part of the Facility to improve skill acquisition programs. In addition, it should be noted that other sections of the current monitoring report reflect considerable improvement in assessments. For example, Sections O, P, and R describe assessments relating to nutrition, communication, and physical/occupational therapy that were sophisticated and integrated with other services provided to individuals living in the Facility.

Presented below are areas in which substantial weaknesses continued to exist based upon the sample used to assess performance in relation to Section S.

Task analysis

Conducting a meaningful task analysis is essential to the development of many, but not all, skill

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| | | 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.<br><br>Eight of the 24 SAPs in the current sample (33%) did not require a task analysis. The remaining 16 SAPs reflected either forward- or backward-chaining, procedures that would necessitate a formal task analysis. Although the majority of these SAPs did include steps that were labeled as a task analysis, there was no indication that a formal assessment process had been used to identify or select the appropriate steps for each individual. As a result, there was no evidence to support that these 16 SAPs had been based upon a task analysis.<br><br><u>Behavioral objectives</u><br>Ten of the 24 reviewed SAPs (42%) reflected adequate behavioral objectives. Objectives should define the conditions under which the skill will be performed, the actions that constitute successful performance of the skill, and the criteria for measuring success. In addition, the objective should define a timeframe for success that reflects an understanding of the individual's potential, allowing adequate time for success without perpetuating training indefinitely. Of the 14 SAPs that were considered to have inadequate behavioral objectives, all included excessively long periods during which training could continue. For example, the objective for Individual #353 defined success as correct responses in 20 out of 24 trials within a year. Based upon the objective, the individual could hypothetically provide only incorrect responses for over seven months without necessitating a revision to the SAP. The lack of individualized timeframes, along with timeframes that allowed for lengthy periods without progress, was the primary reason why the objectives were inadequate.<br><br><u>Operational definitions</u><br>Sixteen of the 24 reviewed SAPs (67%) reflected adequate operational definitions. An operational definition identifies the components of the behavior in objective and measurable terms, provides sufficient clarity so that a naïve observer could recognize the behavior, and is sufficiently thorough so that the behavior and other similar yet different behaviors can easily be differentiated.<br><br>Examples of SAPs that did not reflect adequate definitions included the following.<br>• For Individual #617, the operational definition of making a choice involved either stating a choice or touching an item. Instructions to staff, however, required the individual to state a choice. As there was no indication of which criterion was correct, this discrepancy was likely to result in errors in SAP implementation and data recording.<br>• For Individual #637, the individual was to identify 12 o'clock. The SAP did not include a definition of how identifying 12 o'clock was to be performed.<br><br><u>Description of teaching conditions</u><br>Eleven of the 24 reviewed SAPs (46%) reflected an adequate description of teaching conditions. For a | |

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| | | SAP to be implemented correctly there should be a description of where teaching will be conducted, how to arrange and present teaching materials, and how to provide an environment that is conducive to learning.<br><br>An example of SAPs that did not reflect adequate descriptions of teaching conditions included the following.<br>• For individual #690, the SAP involved teaching the individual to make a choice. The description of the teaching conditions stated only that the individual would be provided with an activity, item to purchase or a menu. The individual was then expected to select an activity, an item to purchase or menu item. There were no further indications for staff on how to prepare the environment or conduct training. It would have been helpful to indicate in which community settings the training was to be performed, provide specific examples of what options the individual was to be offered, and indicate how those options or items were to be presented.<br><br><u>Sufficient trials</u><br>Two of the 24 reviewed SAPs (Individuals #4 and #565, 8%) reflected sufficient trials for learning to take place. 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. In the majority of skill acquisition programs reviewed at DSSLC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill.<br><br><u>Relevant discriminative stimuli</u><br>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 16 of the 24 SAPs (67%), a specific prompt was to be delivered at the beginning of training that could have served as a discriminative stimulus. For the remaining SAPs, either no prompt was required or the prompt described in the SAP was too vague to serve as a discriminative stimulus.<br><br><u>Specific instructions</u><br>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. Only 14 of the 24 SAPs (58%) included adequate instructions for staff.<br><br><u>Opportunity for the target behavior to occur</u><br>Twenty of the 24 reviewed SAPs (83%) reflected the opportunity for the target skill to be performed. | |

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| | | (The four SAPs that lacked this involved Individuals # 206, #637, #690, and #774). This was a slight regression from previous site visits, although the percentage remained relatively high. It must be noted, that the opportunity for a behavior to be performed does not ensure that the behavior will be performed or that the opportunity will occur in the context of a teaching program; instead, actual training would need to occur and be documented. A person could have a SAP to teach appropriate greeting skills. Through the course of a day, the person might experience a dozen circumstances in which the targeted greeting skills could be used, but training might not be provided. If staff do not implement the program according to instructions and document the training according to specific data collection procedures, there is no way to know if the program was implemented or if the targeted greeting skills were exhibited. Therefore, circumstances could allow for ample opportunities for the behavior to be displayed and yet training not be done frequently enough for learning to take place. Furthermore, in such a case, the individual might exhibit (and even be reinforced for) behaviors that interfere with the behavior to be learned; for example, avoiding individuals who they might greet, or hitting such individuals, might result in attention or escape that could be reinforcing.<br><br><u>Specific consequences</u><br>Nineteen of the 24 reviewed SAPs (79%) reflected specific consequences for correct responses, while 20 of the 24 reviewed SAPs (83%) reflected specific consequences for incorrect responses. This was an improvement over previous site visits. Those SAPs that did not include adequate consequences often lacked specific instructions or defined a correct or incorrect response rather than describing the appropriate consequence.<br><br><u>Documentation methodology</u><br>Eighteen of the 24 reviewed SAPs (75%) reflected a potentially adequate documentation methodology. 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. The data collection process must provide specific instructions for when to document performance, how to record the data, and the forms or tools that are to be used. In addition, an adequate data collection system must involve collecting data with sufficient frequency to ensure that a valid estimate of individual performance is achieved.<br><br>To assess whether the documentation methodologies were sufficient to produce adequate data collection, 20 SAP data collection forms located in the residences were selected by choosing the top or first data collection book from the storage location in each residence visited and reviewing the current form for the first SAP listed. Of the 20 data forms reviewed, 14 (70%) reflected incorrectly recorded data or had missing data. As a result, even though instructions appeared to be adequate, the majority of data forms reflected substantial errors.<br><br><u>Plan for maintenance and generalization</u><br>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 | |

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| | | that same skill at home, 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. Eighteen of the 24 the skill acquisition programs reviewed at the Facility (75%) included specific plans for generalization.<br><br><u>Promotion of growth, development, and independence</u><br>Despite some noted improvement, due to the limitations presented above, none of the 24 reviewed SAPs (0%) was likely to promote growth, development and independence.<br><br><u>Engagement, activities, and informal skill acquisition training</u><br>In addition to substantial weaknesses relating to skill assessment and SAP development, The Facility also demonstrated substantial limitations regarding the provision of active treatment. The Facility did have in place a system for monitoring active treatment or engagement. Despite a considerable investment of time by the Facility, however, evidence did not reflect that this system produced accurate information or resulted in adequate levels of engagement.<br><br>The Monitoring Team conducted observations in a variety of settings across the Facility. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior. Individuals included in the observations were Individuals #24, #34, #53, #87, #88, #141, #188, #189, #195, #209, #313, #332, #362, #417, #485, #608, #705, #706, #772, and #774. | |

| | Staff Present | Individuals Present | Individuals Functionally Engaged | Percent Functionally Engaged |
|---|---|---|---|---|
| 508a | 4 | 7 | 3 | 43% |
| 508c | 2 | 5 | 5 | 100% |
| 508a | 5 | 8 | 8 | 100% |
| 522a | 1 | 3 | 1 | 33% |
| 522a | 2 | 6 | 2 | 33% |
| 515a | 3 | 3 | 3 | 100% |
| 515b | 1 | 1 | 0 | 0% |
| 507a | 2 | 8 | 2 | 25% |
| 506c | 1 | 4 | 1 | 25% |
| 505c | 3 | 3 | 2 | 67% |
| 502b | 1 | 4 | 4 | 100% |
| 502c | 12 | 2 | 1 | 50% |
| 502c | 2 | 4 | 3 | 75% |
| 502d | 2 | 3 | 1 | 33% |
| 512d | 2 | 8 | 3 | 38% |

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| | | | | | |
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| 515d | 1 | 4 | 1 | 25% |
| 515c | 3 | 4 | 4 | 100% |
| 524a | 3 | 5 | 4 | 80% |
| 524d | 1 | 4 | 1 | 25% |
| Total percentage of individuals functionally engaged | | | | 57% |
| Percentage of locations with 50% or greater functional engagement | | | | 47% |

Observations revealed that across all settings 57% of observed individuals were functionally engaged. Furthermore, only slightly less than half (47%) of all environments observed reflected at least 50% engagement. Specific concerns noted during observations included the following.

- Individual #121 was observed to have swelling and bruising on his face and head. During observations on his residence, the individual struck his face and head 37 times in three minutes. Staff did not attempt to block the behavior or otherwise intervene.
- During dinner on residence 515D, one individual was asleep at the table. Although only four individuals were present, more than five minutes was required to bring a meal to each individual. Seven minutes after one individual began eating, staff checked his dining card and then moved him from his wheelchair to a dining chair.
- During dinner on residence 524A, one staff made the following comment to a second staff regarding an individual: "Put him in his room until I'm finished so he don't bust his head."

Although some observations conducted at the Facility reflected low levels of functional engagement, in several other settings staff exhibited the skills necessary to maintain reasonable levels of engagement and training.

- Staff on residence 512D were using paired choice presentation to identify which lip balm each individual preferred.
- On residence 508A an individual was observed who during previous site visits had spent the majority of time crawling about on the floor unattended. During the current observation, the individual was seated quietly on a soft floor mat with a preferred item. Intermittently staff would place a preferred item on a nearby shelf. The individual would stand, walk to the shelf, and retrieve the item. This was a good example of structuring the environment to encourage desired behavior and promote learning.
- On residence 502C during snack, staff were observed effectively using prompting and positive reinforcement to promote dining skills.

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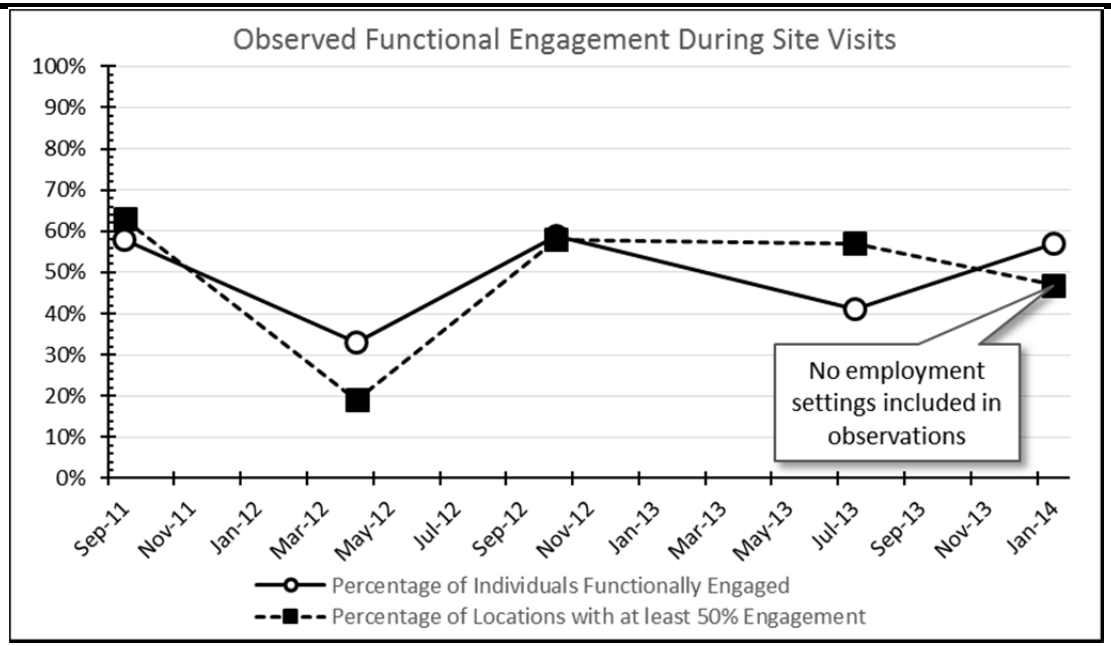
| | |  <br><br>Based upon information obtained from site visit observations, it was reflected that the Facility had achieved considerable progress in relation to functional engagement. Although a drop was reflected in locations with at least 50% functional engagement, it should be noted that, during this compliance visit, no observations were conducted in an employment setting as had been done at past visits. As employment settings historically have involved near 100% engagement, the size of the noted drop is more suggestive of increased engagement in residences rather than an overall drop in engagement. | |
| 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 | <u>Historical Perspective</u><br>During the baseline site visit in March 2010, a review of the records for 10 individuals revealed that formal assessment of skills, needs, and abilities was lacking at DSSLC. In general, attempts by the Facility to assess individual strengths, limitations, barriers, and preferences typically involved anecdotal statements, narrative reports, and generic rating scales.<br><br>During the April 2012 site visit, records were reviewed for 13 individuals living at DSSLC. That review revealed no individuals included in the review had been provided all necessary assessments. Where assessments were provided, the assessments often did not reflect objective and valid assessment procedures.<br><br>During the July 2013 site visit, documentation indicated that substantial limitations continued | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
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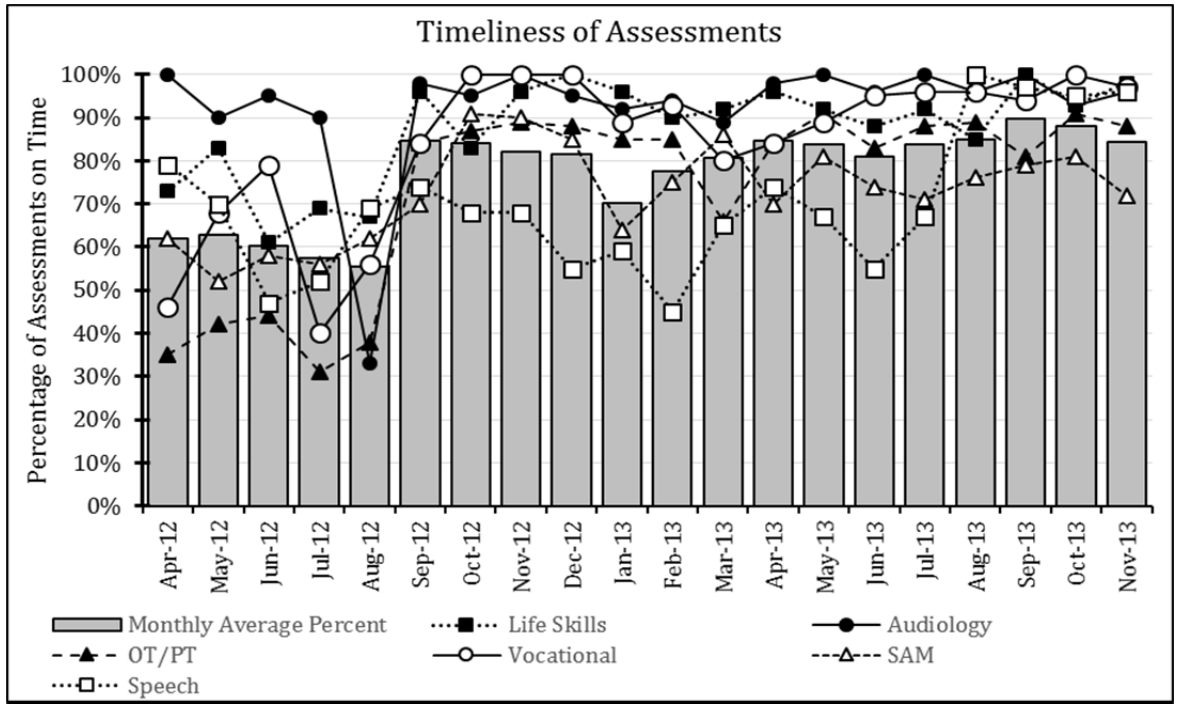
| | in leisure activities. | concerning the content of assessments, the use of assessments in developing SAPs, and insuring that assessments were submitted in a timely manner.<br><br><u>Current Site Visit</u><br>Based upon tracking data maintained by the Facility, it was evident that the Facility had substantially increased the number of required assessment reports completed and submitted in time for the ISP meetings. Nevertheless, documentation reflected several areas in which too few assessments were submitted in a timely manner, such as OT/PT, Self-administration of Medication Skills (SAMS), Psychology, and the Functional Skills Assessment. It was not possible to determine from available data whether the lack of an assessment report contributed to the failure to integrate assessment findings with any specific SAP.<br><br>  | |

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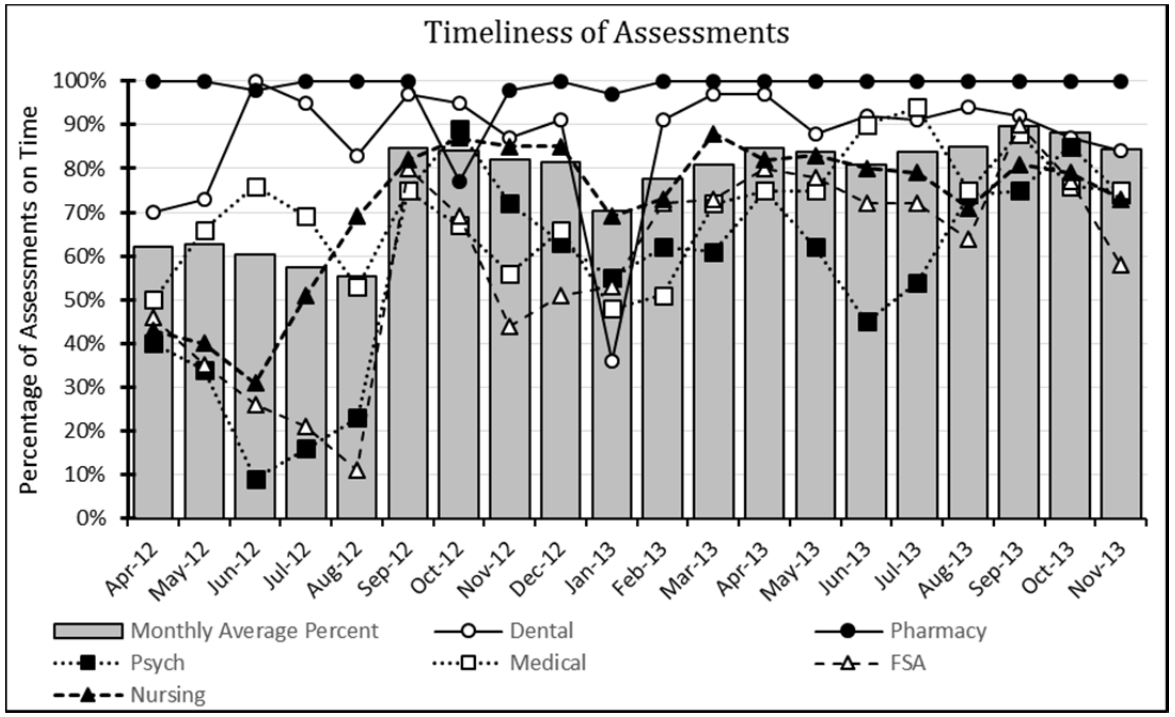
| | |  <br><br>Because of the broad weaknesses in assessment practices at the Facility, it was not evident that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process. Likewise, as multiple departments had not submitted assessment reports on time for the annual ISP, it was not evident that the Facility provided adequate measurement of individual strengths, skills, or needs on at least an annual basis. Although the Facility had improved the percentage of assessments that were submitted on time in comparison with the previous site visit, the percentage of assessments not submitted on time remained unnecessarily high. As a result, the Facility was determined to have not yet achieved substantial compliance with this provision of the Settlement Agreement. | |
| S3 | Within three years of the Effective Date hereof, each Facility | | |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and</td><td>Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that the Facility did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy.<br><br>In very few locations was it possible to observe the implementation of formal skill acquisition programs. To obtain some measure of how well SAPs were implemented and documented, 20 SAPs and the latest data recording form for each were reviewed in individuals' residences. Each SAP and data form was selected by choosing the top or first data collection book from the storage location in each residence visited and reviewing the current form for the first SAP listed. The 20 individuals included in the sample were Individuals #24, #34, #53, #87, #88, #141, #188, #189, #195, #209, #313, #332, #362, #417, #485, #608, #705, #706, #772, and #774.<br><br>The table below reflects the results of the review.<br><br><table><tr><th>Element</th><th>Percent Correct</th></tr><tr><td>Data recording forms present</td><td>100%</td></tr><tr><td>Individual information is correct</td><td>100%</td></tr><tr><td>Data current</td><td>50%</td></tr><tr><td>Plan is implemented according to the specified schedule.</td><td>50%</td></tr><tr><td>Data recorded correctly</td><td>30%</td></tr></table><br>Specific issues noted included the following.<br>• Ten of 20 data sheets (50%) were missing data for at least one trial.<br>• Ten of 20 data sheets (50%) reflected data recorded for each step in a chaining procedure. Data are only to be recorded for the final step in a chaining procedure.</td><td>Noncompliance</td></tr>
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| | | • Fourteen of 20 data sheets (70%) were either missing data or reflected data recorded incorrectly.<br><br>It is suggested that 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 obtain a measure of practical and functional qualities of the SAPs at the Facility, the 14 ISPs and SAPs in the sample for Provision S.1 (Individuals #4, #54, #208, #311, #353, #506, #565, #617, #637, #638, #690, #734, #753, and #774) were rated on five questions. Those questions and the ratings are presented below.<br><br>**Practical** — Percentage of SAPs<br>SAP does not require excessive resources, time or staff. — 86%<br>SAP is not excessively difficult or technical. — 79%<br>SAP can be implemented in relevant environments. — 71%<br>**Functional**<br>SAP addresses specific needs from formal assessment. — 36%<br>SAP targets skills useful for the individual. — 43%<br><br>Specific issues noted functionality included the following.<br>• Only five of the 14 sampled SAPs (36%) addressed specific needs reflected in formal assessments.<br>• Six of the 14 sampled SAPs (43%) targeted skills that would likely be useful for the individual.<br><br>Examples in which a SAP was not functional are presented below.<br>• Individual #54 was provided a SAP to teach him to request work materials. Based upon information obtained from the assessments and ISP, the primary skill deficit did not involve requesting needed work materials. Rather, it was suggested that the individual did not enjoy various job assignments and preferred to work with a specific set of staff. When not involved with preferred job duties or staff, the individual experienced difficulty remaining on task, would damage work materials, and would not initiate work. Based upon this information, it was not evident how training to request work materials would be beneficial for the individual. A more functional SAP might have involved requesting specific jobs or staff, or training on how to appropriate express dissatisfaction. It was also possible that environmental changes might have reduced or eliminated the need for this particular SAP.<br>• Individual #617 was provided a SAP to teach choice-making skills. Individual #617 was almost entirely visually impaired; assessment could not reveal whether he could detect light or motion. Although the SAP had an inconsistently described methodology, none of the instructions accounted for visual impairment. As a result, he was expected to either touch or | |

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| | | state the name of objects that were not presented in a manner appropriate for a person who was not sighted.<br><br>Concerning practicality, none of the reviewed SAPs was overly sophisticated or required expertise a DSP was unlikely to possess. In all cases, the determination of a SAP to be impractical resulted from weaknesses in assessment or instructions that would have prevented the SAP from being implemented correctly.<br>• According to the FSA, Individual #637 lacked an understanding of the purpose of a clock and could not tell time. The SAP, however, called for the individual to use a clock in order to determine when it was time for specific events. As a result, there was no practical means for the trainers to implement the SAP. Furthermore, instructions for staff were not specific concerning the expectations for the individual's behavior.<br>• The SAP for Individual #734 targeted choosing a magazine. The FSA reflected that the individual requires total staff assistance and lacks the ability to indicate a choice. The ISP narrative stated that the individual consistently failed to respond to questions or requests. There was no indication in any documentation that the individual was interested in magazines. Therefore, it was not reasonable to expect that the SAP was practical for the DSP staff to implement.<br><br>Based upon information presented by the Facility, it was evident that progress had been made toward providing training that was practical and functional for the individual. At the time of the site visit, however, considerable weaknesses remained. As a result, the Facility continued to fall short of substantial compliance with the Settlement Agreement. | |
| | (b) Include to the degree practicable training opportunities in community settings. | <u>Historical Perspective</u><br>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. Documentation in July 2013 reflected a continuation of high numbers of community outings involving SAP implementation.<br><br><u>Current Site Visit</u><br>Documentation provided during the current site visit reflected an increasing trend in the number of community outings that included SAP implementation. Outings and community SAP implementation was substantially lower in December 2013 due to especially harsh winter weather that prevented travel. | Noncompliance |

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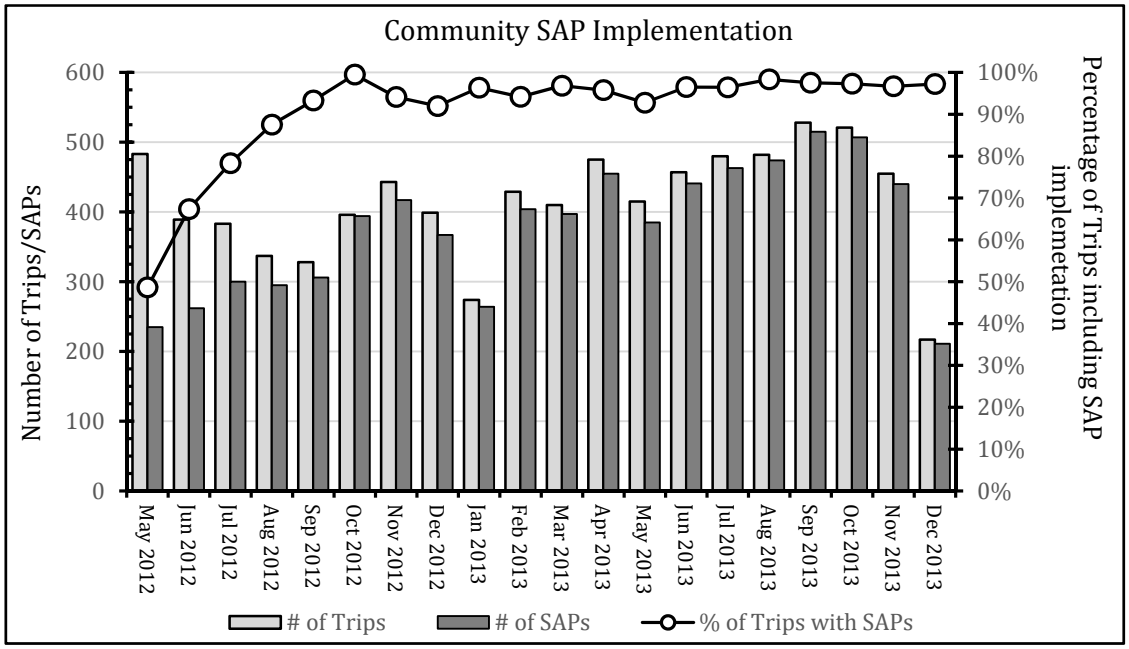
| | |  <br>DSSLC collected and presented an abundance of information regarding skill acquisition programs, community outings, and the details of many of the hundreds of reported outings. Due to the weaknesses noted in the assessment for and development of skill acquisition programs, however, it was not possible to determine if the quality of the SAPs and training was commensurate with the quantity. It would be beneficial for the Facility, as well as the individuals served, for the Facility to maintain a list of the skills taught in the community, the number of training opportunities provided in the community for each individual, and the performance of each individual for SAP training sessions conducted in the community. | |

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
|---|---|
| | **Documents Reviewed:**<br>1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 12/27/2013<br>2. Denton State Supported Living Center Action Plans, Compliance Visit Round 7, Content Updated: 12/05/2013<br>3. Denton State Supported Living Center Report for Monitors, dated January 13, 2014<br>4. Section T Presentation Book materials<br>5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10<br>6. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/2012<br>7. DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, dated May 22, 2013<br>8. DSSLC Policy CMGMT 39.a: Exhibit I: Pre-Placement Medical Chart QA Protocol, dated 3/20/13<br>9. DSSLC Policy CMGMT 39.a: Exhibit J: Pre-Placement Doctor to Doctor Contact Protocol, dated 3/20/13<br>10. DSSLC Policy CMGMT 39.a: Exhibit K: Increasing Individual's Participation at Their Own ISP Meeting, dated 5/17/13<br>11. Plan to Support People to Live in the Most Integrated Setting of Their Choice, undated<br>12. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement<br>13. Since last on-site review, a list of all individuals who have been referred for placement<br>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"<br>15. Since last onsite review, a list of all individuals returned from a community residential placement, and documentation of the facility's review and assessment of each case.<br>16. A list of any individuals who have moved from the facility to the community or for whom the Facility provided post-move monitoring since 7/1/09 and have died<br>17. Potentially Disrupted Community Transitions with a date range of 12/1/12-12/18/13<br>18. A current list of all alleged offenders committed to the Facility following court-ordered evaluations<br>19. For the last twelve months, a list of individuals who were reported to have been assessed for placement<br>20. Community Referral Activities/Status List, undated<br>21. Community Placement Report (CPR), dated Monday, January 13, 2014 for Meeting Dates 7/15/2013-1/13/2014<br>22. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #89, #90, #172, #563, #571, #699, #719, #720 and #759<br>23. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices<br>24. Documentation related to community tours for Individuals #169, #415 and #510<br>25. List of Community Tours, updated 12/2/2013<br>26. Annual Report: Obstacles to Community Referral and Transition, Fiscal Year 2013, prepared November |

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| | 2013<br>27. Individual Support Plans (ISPs), ISP assessments, ISP Preparation documentation and Preferences and Strengths Inventory (PSI) for Individuals #4, #26, #177, #221, #311, #376, #408, #565, #608 and #564<br>28. Denton State Supported Living Center Community Tour Documentation form<br>29. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed<br>30. Completed CLDPs for Individuals #20, #22, #54, #125, #171, #238, #306, #320, #382, #390, #611, #627, #686 and #726<br>31. Partial CLDPs for Individuals #5, #181, #457, #691<br>32. CLDP Assessment Checklist, undated<br>33. CLDP Helpful Hints, undated<br>34. Pre Move Site Reviews for Individuals #20, #22, #54, #125, #171, #238, #306, #320, #382, #390, #611, #627, #686 and #726<br>35. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals<br>36. Post-Move Monitoring Checklist, revised May 2013<br>37. Completed Post Move Monitoring (PMM) checklists for Individuals #20, #22, #54, #125, #133, #171, #217, #229, #238, #265, #306, #320, #359, #382, #385, #390, #444, #476, #611, #627, and #686<br>38. Potentially Disrupted Community Transition Documentation for Individuals #232 and #306<br>39. Integrated ISP Monitoring Tool<br>40. QA/QI Data Meeting, Section T Most Integrated Setting, dated November 19, 2013<br>41. Discharge packet for Individual #119<br>**People Interviewed:**<br>1. Clark Clermont, Director of Community and Family Relations (CFR)<br>2. Leslie Clark, QIDP Coordinator<br>3. Andy Maher, Post-Move Monitor<br>4. Lori Powell, Quality Assurance (QA)Director<br>5. Eileen Short, Transition Specialist Coordinator<br>**Meeting Attended/Observations:**<br>1. Annual ISP meetings for Individuals #228, #567 and #791<br>2. ISP Preparation meeting for Individuals #182 and #487<br>3. Post-Move Monitoring Visit for Individual #726 |
| | **Facility Self-Assessment:**<br>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 in part on data collected through the Facility's QA/QI processes, including the Integrated ISP Monitoring Tool. In order to improve its Self-Assessment for use in achieving compliance, the Facility should review the criteria |

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| | by which it assesses that compliance. The criteria did not always address the noncompliant findings from the Monitoring Team. For example, for Provision T1b2, the Facility reported it reviewed CLOIP data as a part of its compliance testing, which indicated that families were sent living options material and follow-up calls had occurred. The Monitoring Team's findings regarding CLOIP, on the other hand, focused on whether individuals were able to participate in it on a meaningful basis.<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance, including training, monitoring and assuring adherence to current policies. Once it develops provision-specific outcome indicators, the Facility should review these actions to ensure they are focusing on those most likely to support the identified outcomes. 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. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together. 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.<br><br>This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data. For example, a current Action Step for Provision T2a was to enhance the review process by the IDT of Post Move Monitor (PMM) visits. It was designated as completed as of 10/8/2013. There was no methodology for measuring the implementation or the outcomes of this Action Step, and documentation obtained by the Monitoring Team during this visit revealed minimal implementation had been achieved. For the Action Steps to have a positive impact on achieving substantial compliance, the Facility should define the provision-specific outcomes it hopes to achieve as a result of each Action Step as well as how each will be measured.<br><br>**For Provision T1**, the Facility indicated it was not in substantial compliance with this 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 substantial compliance for T1c2, T1c3, and T1h, but did not concur for T1b2, T1e or T1g.<br><br>**For Provision T2**, the Facility self-rated noncompliance in Provision T2a but did not provide its reasoning |

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| | for this evaluation. 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. The Monitoring Team was not able to substantiate compliance for either of the provisions.<br><br>**For Provision T3,** no compliance rating is required.<br><br>**For Provision T4,** the Facility indicated it remained in substantial compliance. This was based on a previous compliance rating and no changes in the process having been made. The Monitoring Team did not concur. |
| | **Summary of Monitor's Assessment:**<br>This Section was found to be not in compliance overall. A summary of noted progress included a continued relatively high number of referrals and transitions. The Facility was also to be commended for enhancing staffing resources sufficient to meet the additional demands resulting from its relatively high number of referrals and transitions. Other specific findings are detailed below:<br><br>**For Provision T1**, fourteen individuals had transitioned to community living and there were 31 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. 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 address the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences. 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.<br><br>**For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. There was a single Post-Move Monitoring position at the time of the monitoring visit. A change in staffing for this position had occurred since the last monitoring period, but any potential disruption appeared to be minimized by the selection of a former Director of CFR to fill this crucial post. In addition, the Facility had recently hired a Master's level Social Worker to assist with both transitions and post-move monitoring. The Facility was to be commended for providing sufficient resources to meet the additional demands resulting from its relatively high number of referrals and transitions.<br><br>PMM Checklists were being completed in a timely manner and included visits to all sites at which the |

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| | individual lived and worked/day activity, as required. The PMM Checklists reviewed in depth indicated that post move monitoring appeared to have been conducted in a thorough manner. However, the failure of the IDTs to adequately describe the full set of supports, services and protections needed and the specific evidence required to verify their presence made it difficult to perform an accurate assessment using only the paperwork. The Monitoring Team found continuing deficiencies in the monitoring processes over the course of the last six months. There were examples in which the Facility did act to ensure appropriate supports were provided; however, the Monitoring Team found evidence in the documentation provided that the Facility did not yet consistently take assertive action on a continuing basis to ensure supports were implemented.<br><br>The Monitoring Team found there was progress in the rigor with which the PMM visit was completed. There were no obvious deficiencies in the monitoring process during on-site PMM visit and was impressed with diligence of the Post-Move Monitor. Deficiencies in the overall process of PMM remained, however, resulting from a lack of adequate detail in the CLDP, as described in Provision T1e and lack of appropriate and needed follow-up as described in Provision T2a. As a result, it was not possible to conclude this provision was in yet substantial compliance.<br><br>**For Provision T3**, no rating is required.<br><br>**For Provision T4**, the Facility reported one Alternate Discharge during the past six months. A discharge plan sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement was not provided. The IDT did not provide an adequate final summary of the individual's developmental, behavioral, social, health and nutritional status or adequately describe the key supports that the individual would need in the new setting. |

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| **T1** | **Planning for Movement, Transition, and Discharge** | | |
| T1a | Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community | <u>Transition Outcomes During Last Six Months:</u><br>• Community Transitions: The number of community transitions showed a stable or increasing trend.<br>o There were 14 transitions to community living since the last monitoring visit. With 469 individuals currently living at DSSLC, this represents approximately three percent of the population. This figure represented a continuing trend since the previous monitoring period in which 15 individuals had transitioned.<br>o The transition process took more than 180 days for eight of the 14 (57%) individuals.<br>• Referrals for Community Transitions:<br>o The number of community referrals indicated a continuing trend. | Noncompliance |

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| | 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. | Fifteen referrals had been made since the last monitoring visit, according to the Community Placement Report.<br>o Thirty-one individuals were on the active referral list (approximately 7% of the current population at DSSLC).<br>o Fifteen of the 31 (48%) individuals had been on the referral list more than 180 days, but there was progress noted in that none appeared to have been on the list for more than one year.<br>• Individuals requesting placement, but were not referred: Twenty-five individuals were listed as preferring community living, but not referred. It appeared that none of these had occurred within the past six months, however; all of the meeting dates referenced were from earlier months and years. In the case of those who preferred community, but were not referred due to LAR choice, three of four were from meeting dates more than one year past. It was unclear whether those individuals' status in this regard had been updated since then.<br>• Rescinded Referrals:<br>o There were five rescinded referrals reported since the last review.<br>o Of these, the reasons for the rescinding appeared to be well-documented by the IDT for all five (100%). Three rescissions were as the result of LAR choice, while two were related to medical and/or psychiatric issues<br>o There did appear to be some need for a review to be conducted to determine if changes in the referral and transition planning processes were needed at the Facility in the case of Individual #667. The IDT documented in an ISP addendum that the referral was to be rescinded because more time was needed to explore community living due to the individual's sensitivity to environmental change. There was not, however, any documentation that the plan developed at the ISP annual meeting six months ago for a slow and careful introduction to a foster care provider had been attempted, even though it was designed to address the aforementioned sensitivity.<br>• Returns from Community Placement<br>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.<br>• Deaths Following Community Placement<br>o Since the last onsite review, there had been one death of an individual who had moved from DSSLC to the community. The individual had transitioned on 2/5/13 and the death occurred on 12/18/2013. The | |

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| | | IDT met to review the circumstances on 12/20/2013. Very few details were available regarding the cause of death at that time and no additional follow-up had been completed that might have allowed the Facility to ascertain if changes in the referral and transition planning processes at the Facility should be made.<br>• Other Adverse or Unexpected Outcomes: The Facility provided a list of Potentially Disrupted Community Transitions with a date range of 12/1/12-12/18/13.<br>• During the past months preceding this monitoring visit, four of the 14 (29%) individuals who transitioned during that period had experienced one or more other untoward events since placement. Of these, there was documentation provided of a review conducted for one (25%) of the cases. This review did not appear to be adequate to determine if changes in the referral and transition planning processes at the Facility should be made.<br><br><u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u><br>During this past six months, DSSLC had taken and/or continued to implement 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:<br>• Either the APC 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.<br>• The Facility had added a position to the Department of CFR to assist with transitions and post-move monitoring and recently hired a Master's level Social Worker to fill that position.<br>• A Referral Review Committee continued to meet 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 | |

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| | | Monitor. The group reviewed a tracking database, made any additions needed, discussed issues and problem-solved as needed.<br>• The Director of CFR attended the daily Integrated Morning Report (IMR) meeting and reported weekly on the status of referrals and updated the members on post-move monitoring outcomes.<br>• An Admission and Training Review Team reviewed and discussed post-move monitoring for individuals who had recently moved or for whom a move was anticipated. This meeting, which involved participation by the Facility Director, Director of Residential Services, Chief Nurse Executive, Habilitation, Director of Behavioral Services, QIDPs, Unit Nurse Managers, and others, had the potential to improve the immediacy of responding to issues that may emerge when people transition out.<br>a. The Facility continued to implement the Pre-Placement Medical Chart QA Protocol, a Pre-Placement Doctor to Doctor Contact Protocol.<br><br><u>Conclusion:</u> 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: | <u>Policies and Procedures related to transition and discharge processes</u>:<br>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. DADS policy for most integrated setting practices was recently issued. The Monitoring Team will comment at the next compliance review as to whether this policy adequately addressed all the items in Section T. | 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 | <u>Protections, services, and supports:</u><br>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 | Noncompliance |

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| | most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles. | 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.<br><br><u>Identification of and Plans to Overcome Obstacles to Transition:</u><br>DSSLC reported it gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles. These included:<br>• Individual's reluctance for alternate placement<br>• LAR's reluctance for alternate placement<br>• Lack of supports for people with significant challenging behaviors<br>• Lack of availability of specialized therapy supports<br>• Lack of availability of specialized medical supports<br>• Lack of funding due to an individual's legal and citizenship status<br>• Lack of specialized mental health supports<br>• Need for environmental modifications to support the individual<br>• Need for services and supports for persons with forensic needs/backgrounds<br>• Lack of specialized educational supports<br>• Need for transportation modifications to support the individual<br><br>Of ten sample ISPs reviewed, the Monitoring Team found that nine of ten should have had obstacles to referral defined. Of these nine ISPs, all had obstacles defined (100%), but none (0%) included an adequate discussion of these obstacles to referral. For the tenth ISP, a referral was made and there was discussion of enhanced level of supervision related to PICA as a potential obstacle to transition. Plans to address obstacles at the individual level were universally not adequate. Of the ten ISPs, none (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles.) Examples included:<br>• For Individual #177, the IDT did not provide a clear definition of the actual obstacles to living in less restrictive environment or create appropriate Action Plans to address obstacles. In the Living Options Recommendations section, it indicated the facility discipline members determined the individual could not be served in a less restrictive setting based on intensive needs for medical care. This statement contradicted the physician's recommendation in the annual Medical Assessment that the individual could be served in a less restrictive setting and furthermore recommended referral for community transition. The Living Options rationale then continued with a statement that the team's professional opinion was that the individual would be able to receive the degree of medical services needed, but it would pursue community options once the | |

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| | | guardian gave permission for the individual to tour community homes. LAR choice was then the only obstacle selected from the list of approved obstacles; no further reference to the individual's medical needs was made. The corresponding Action Plan was for the individual to attend community outings to various places off campus. There was no indication of how this would address LAR choice.<br>• For Individual #565, the IDT also did not provide a clear set of obstacles based on assessments or appropriate corresponding Action Plans. It determined the individual could not be served in a less restrictive setting and listed in the Living Options Recommendation narrative section the potential for medical complications and behavioral issues as well as the unknown preference of the individual as the reasons for this decision. Professional assessments did not consistently support these determinations, as nursing, OT/PT and behavioral assessments all indicated the individual could be served in a community setting. There was no discussion documented as to these discrepancies or how they were resolved. The final obstacles chosen from the approved list were Individual choice and medical issues. Behavioral health/psychiatric needs was not selected as an obstacle, despite the rationale in the narrative section. The only Living Options Action Plan was for the individual and family to receive an annual information packet and be invited to review the information.<br><br><u>Preferences of Individuals and LARs</u><br>Of ten sample ISPs, 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.<br><br>At the time of the last monitoring visit, the Facility reported it had developed and was implementing a plan to address issues related to the unknown preferences of individuals. A review of ISPs had indicated that the largest group of those with unknown preferences was made up of individuals who did not have sufficient awareness to provide an indication. 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. As further described in Provision T1b2 below, community tour documentation indicated there had been minimal implementation of this strategy.<br><br>Preferences of LARs and families for living arrangement were typically more often understood and documented. The Facility was providing some opportunities for families | |

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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.<br><br>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:<br>In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria:<br><br>An Individualized Plan For Each Individual: The Monitoring Team found there continued to be little attention devoted to careful assessment of the individual's specific need for education in this area, even when lack of awareness was identified as an obstacle to movement. For none of the ten (0%) ISPs was there an adequate individualized plan for increasing awareness of community living options that took into account the learning needs of the individual.<br><br>An Annual Provider Fair: The Facility holds a Provider Fair on a semiannual basis. The most recent was held on 9/13/2013. As reported in its Self-Assessment, this Fair was held on the weekend. Attendance compared to the last Fair, was improved for staff, individuals and family/LARs. On the other hand, the number of providers attending the weekend Fair was half of the weekday Fair. The Facility continued to complete a survey of the participants in the Fairs. The responses overwhelmingly were the Provider Fair was excellent and informative. The Facility had also used these data to vary its approaches to this activity. For example, the survey data from the previous Fair indicated providers would benefit from training in positive behavior support. Following the most recent Fair, providers were given the opportunity for an in-service by a Board Certified Behavioral Analyst. The Provider surveys further indicated the training was helpful. DSSLC also encouraged the HCS providers to contact Facility BCBAs with any requests and offered to provide training to providers requesting training. This was a very positive outcome.<br><br>Regular SSLC Meeting With Local LAs: DSSLC staff had routinely held joint Interagency Planning Meetings with local LAs to coordinate admissions and discharges as well as to jointly plan for education about community living options; however, no quarterly meetings had been documented since the last monitoring visit.<br><br>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 | Noncompliance |

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| | | community living, nor for using such information to evaluate opportunities to improve outcomes. Examples included:<br>• 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.<br>• CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of nine CLOIP Worksheets for recent ISPs. For these individuals, three of nine (33%) were allowed by the LAR to participate in the CLOIP. For none of the three (0%) in which the LA was permitted to engage the individual, was the LA Service Coordinator able to document the individual had any interest in or meaningful response to the materials or information being offered. In each of these three, 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.<br><br>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:<br>• Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): Between 7/24/2013 and 12/2/2013, according to the report provided, the Facility documented a total of 16 individuals who had participated in community tours. Thirteen of 16 (81%) 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 with which to form any preferences. The Facility had reported during the previous monitoring visit that it was aware of this concern and was developing a strategy to address it. There did not appear to be such a strategy in place as of the time of this monitoring visit. Only three individuals not on the referral list had made 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 469 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in informed decision-making. | |

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| | | • Places chosen to visit are based on individual's specific preferences, needs, etc.: An individualized education and awareness plan should define the types of settings to which an individual may need exposure to facilitate his or her understanding of community living options. There was not a yet consistent or formalized process described for choosing tour sites based on individual preferences and needs.<br>• Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. The size of tours at the Facility continued to be conducive to both individual learning and assessment of responses.<br>• 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. The Monitoring Team requested the tour documentation and evidence of IDT review of the individual's response for three individuals who went on tours in July and August 2013. There was tour documentation for two of the three (67%), but there was no IDT review documented for any of the three (0%). The Facility noted in the QA/QI Data Meeting for Section T Most Integrated Setting, dated November 19, 2013, that gaining feedback on community tours remained problematic and was planning to develop a process or otherwise ensure the current process provided the necessary documentation.<br><br>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.<br><br>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 agendas.<br><br>A Plan For Staff To Learn More About Community Options: The Facility indicated in its 2013 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 | |

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| | | participation in community tours, community exploration activities for individuals, and transition related visits. The Facility provided a list of staff participating in such activities since the last monitoring site visit, including tours and visits. It was reported that 28 staff took part in tours of community living options. Staff also had the opportunity to attend the Provider Fairs and the Facility documented 167 staff who took advantage of this event in September 2013.<br><br>The Director of CFR also regularly 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. He also reported an expanded emphasis on education about the Olmstead decision. Between July and November 2013, this reached 259 new staff.<br><br>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories: The Transition Specialists had begun to develop written success stories about individuals who had transitioned. The Facility provided two well-written examples for review that were reported to be pending publication in the DSSLC Grapevine newsletter.<br><br>Conclusion: 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 individuals for placement pursuant to its new or | Percentage of Individuals Assessed as Required:<br>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 | Noncompliance |

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| | 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. | 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.<br><br>The Facility provided a list of 469 individuals in response to the document request for the number of individuals who had been assessed for placement in the past twelve months. It also provided a revised and expanded description of the process in use for this assessment:<br>"All individuals are annually assessed for the most integrated setting. This occurs at least annually through the Living Options discussion during the individual's ISP. The IDT considers several factors during this discussion. The individual may also be considered for community placement at any time. The process also starts whenever a request for community placement is received by the individual or family/LAR.<br><br>At this time, the team evaluates the individual's current progress, services, supports and needs. Preferences are reviewed and the extent of the individual's awareness of alternative living options. The person's medical, psychological/psychiatric, behavioral, specialized therapy services and emotional needs are also considered. As much as possible, a complete picture of the individual is brought into the discussion.<br><br>Once a clear picture of the individual is discussed, then the protections, services, and supports that would be required if the individual chose to move to a more integrated setting is considered. 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.<br><br>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 | |

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| | | question of whether the service could be delivered in a less restrictive setting. They must then make a recommendation based on the unique circumstances for that individual. Ideally, the individual, LAR, and team must all be in agreement about a recommended choice of living option. However, it is clear that an individual's or LAR decision is final in this area of service decisions.<br><br>The culmination of assessing the individual for community placement occurs by the completion of a Community Living Discharge Plan (CLDP). The individual has been assessed by all involved service disciplines and supports and services are developed to ensure these preferences and needs are met."<br><br>Overall, the process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement. Issues that affected the adequacy of the assessment included:<br>• 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 needed to continue devising strategies to address this issue.<br>• As described in Provision T1b1, the IDTs continued to lack proficiency in 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.<br>• For the ten ISPs reviewed, there were a total of 98 discipline-specific assessments reviewed. Of these, 55 (56%) included a determination of whether the individual could be served in a less restrictive setting.<br>• Of the 98 assessments reviewed, only two (4%) included substantive and discipline-specific recommendations for how the individual's needs could best be met in a more integrated setting.<br>• In ten of the ten (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, as those assessments almost uniformly indicated the individual could be served in a less restrictive setting.<br>• In none of the ten (0%) written ISPs reviewed did a thorough discussion of living options occur (i.e., consideration of different types of community living | |

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| | | settings, locations, preferences, safety needs, etc.) The ISP for Individual #221 did evidence some progress in this area.<br><br>The Facility had implemented a Corrective Action Plan (CAP) on 12/15/2013 to encourage a fuller discussion of Community Living Options. The CAP, which was ongoing at the time of this monitoring visit, called for staff completing ISP monitoring with the ISP Integrated Monitoring Tool to provide immediate technical assistance and prompting to the IDTs during the ISP annual planning meeting when needed to ensure living options were thoroughly discussed. This process had been implemented six times since the CAP began, with one referral having been made from those respective ISPs. The Monitoring Team looks forward to reviewing the outcomes of this CAP at the time of the next monitoring visit.<br><br><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>:<br>The Department of CFR was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. The Facility continued to use Form SSLC 018E, March 2013, as the format for the CLDP. The Facility also continued two practices 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.<br><br><u>Timeliness of Development and Implementation of CLDP:</u><br>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 four CLDPs in progress for referrals made during the past six months. A fifth was requested, for Individual #563, but was not provided. It was unknown whether this indicated the CLDP had not been initiated, or was simply an oversight:<br>• Three of the four (75%) CLDPs in progress provided were initiated within 10 calendar days of referral as required by policy. For one CLDP in progress, for Individual #181, the first step in the process of completing the Profile was not completed for almost two months.<br>• Four of four (100%) CLDPs in progress provided included adequate documentation to show that they were being updated throughout the transition planning process. Overall, the Monitoring Team found that documentation kept by the Transition Specialists, who were designated to maintain the referral status updates, was frequent and detailed. | Noncompliance |

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| | | The Monitoring Team also reviewed an updated Community Placement Report, updated on Monday, January 13, 2014 for Meeting Dates 7/15/2013-1/13/2014, which revealed:<br>• Fifteen of the 31 (48%) current referrals had exceeded the 180 days allowed in the current policy and pending revision.<br>• Eight of the 14 (57%) transitions that had occurred also exceeded 180 days.<br><br>Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. DAD's policy also acknowledges this and provides a process for the IDT to meet and review when the 180-day threshold has been reached. The Facility also continued to hold a Referrals Review meeting, a formalized weekly review of existing referrals by the Department of CFR and the Transition Specialists. The Monitoring Team again commends the Facility and the Department of CFR for implementation of this strategy. It appeared it was continuing to contribute to a more effective and timely process for transitions to occur.<br><br>It also appeared that there was progress in the pace of community exploration as there were fewer delays in initiating these activities following the initial referral meeting or in sustaining that activity at a reasonable pace. For example, the Monitoring Team reviewed four CLDPs in process to evaluate whether the Facility was compliant with its policy to document transition activity on an ongoing basis. Three of four (75%) 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. 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.<br><br><u>Development of CLDP in coordination with the LA:</u><br>A review of a sample of five completed CLDPs (for Individuals #20, #171, #306, #320 and #726) 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.<br><br><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, but the timelier outcomes were occurring for most individuals referred in recent months. Coordination with the LA in the development of the CLDP did not appear | |

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| | | to be of significant concern at this time. There did remain, however, concerns related to the adequacy of the CLDPs that were developed, primarily the failure by the IDTs to adequately identify the appropriate essential (by day of move) and nonessential (following move) supports for each individual. These deficiencies are described in more detail in Provisions T1c1, T1c2, and T1c3 below. | |
| | 1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff. | None of five (0%) completed CLDPs reviewed 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.<br>• Training of community provider staff, including staff to be trained and level of training required.<br>• 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.<br>• Assessment of settings by SSLC clinicians (e.g., OT/PT)<br>• Collaboration between provider day and residential staff is ensured<br>• SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community)<br>• Collaboration between Post-Move Monitor and Local Authority staff<br><br>None of five (0%) CLDPs reviewed clearly identified a set of activities to occur on the day of the move that also included the responsible staff member and documentation that the activities did indeed occur. Certain day of move activities were listed in the CLDP, but responsible staff were not consistently identified. No day of move documentation was provided with the CLDP, so a full evaluation could not be completed. In some instances, the 7-Day Post-Move Monitoring did make note these activities had occurred.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | Noncompliance |
| | 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><br>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.<br><br><u>Completion timeframes for needed actions identified</u>: | Substantial Compliance |

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| | | 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.<br><br>Conclusion: This provision was found to be in 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. | Evidence of individual/LAR participation:<br>Based on review of five CLDPs, five (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.<br><br>Conclusion: This provision was found to be in substantial compliance. | Substantial Compliance |
| T1d | Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving. | Timeliness of Assessment:<br>These processes in themselves appeared to be largely adequate for purposes of ensuring that assessments were available and current within 45 days prior to the individual leaving the Facility. The Monitoring Team reviewed the assessment dates for all fourteen CLDPs for individuals who had transitioned during the past four months. For 143 assessments reviewed for currency, only 10 (7%) were not completed within 45 days. DSSLC needed to continue to focus its attention on whether these assessments were adequately prepared as described immediately above.<br><br>Adequacy and Comprehensiveness of Assessments:<br>In order to be considered a current and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the IDT and the community provider would need to develop an appropriate transition plan. 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, many assessments reviewed did not place 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 was some progress noted in this area, however. There was also some progress noted in a focused review of five Nursing Discharge Summaries and Community Living Discharge Planning Packets, as further detailed in Provision M3. For example, five of five (100%) Nursing Discharge Summaries included individuals' assessments, clinical services' needs, and health status in relation to each significant identified health clinical indicators, such that the receiving agency could understand their present health status in order to respond to | Noncompliance |

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| | | their health care needs.<br><br>The Monitoring Team nevertheless found that there continued to be discrepancies and/or omissions 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:<br>• For Individual #306, who transitioned on 9/30/13, the Medical Assessment, dated 9/23/13, noted in the history that the individual was assessed at the clinic on 8/30/13 for PICA behavior and a PICA protocol implemented. There was no further information provided in any of the CLDP assessments as to the nature of the PICA behavior, nor was there any reference to it in the CLDP summary. The provider staff would need to be aware of any recent PICA behavior, particularly since it occurred just one month prior to the transition date. Even if this had appeared to be an isolated event, as no assessment otherwise documented any history of PICA behavior or any further mention of this event, it may have indicated an emerging behavior the provider should have knowledge of.<br>• Individual #320 was diagnosed with Atlanto-axial instability, multi-level degenerative changes to his spine and significant neural foramina narrowing at left C4-C5 and right C5-C6. It was noted in the individual's ISP that he had a follow-up appointment with Neurosurgery on 10/17/13. The CLDP was held on 10/21/13 and there was no documentation that any of the assessments, or the CLDP narrative, were updated with the findings of the Neurosurgery consult. No specific supports were identified in the CLDP.<br><br>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:<br>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 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 | <u>Identification of Pre and Post Move Supports</u>:<br>In none of the five (0%) completed CLDPs reviewed 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:<br>• The list was comprehensive and inclusive, demonstrated by: | Noncompliance |

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| | 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. | o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems.<br>o All safety, medical, healthcare, risk, and supervision needs were addressed.<br>o What was important to the individual was captured in the list of Pre and Post Move supports.<br>o The list of supports thoroughly addressed the individual's need/desire for employment.<br>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.<br>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.<br>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.<br>o Topics included in training had a corresponding Pre and Post Move support for implementation.<br>• The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms.<br>• 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.<br>• 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.<br><br>Examples of deficiencies as to the above criteria in the CLDPs reviewed included:<br>• As described above, the CLDP did not address the PICA behavior recently documented for Individual #306, and no supports were identified. There was no rationale or justification provided for this potentially serious issue to not be addressed. Also as described above, the CLDP did not include supports specifically related to the standard precautions provider staff needed to follow related to the individual's orthopedic instability. The pre-move supports called for the RN Case Manager to in-service the provider nurse on current nursing problems, but this issue was not included. It was also not addressed in post-move supports. As further described in Provision M3, a review of five Nursing | |

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| | | Discharge Summaries and Community Living Discharge Planning Packets indicated they did not consistently include adequate documentation regarding review/training provided to the group home nurses in several crucial areas such as medications, individual risks and health care plans.<br>• For none of five (0%) CLDPs reviewed was there sufficient description or adequately defined criteria of what the Post-Move Monitor should look for. 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, 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; he must rely on the expertise of the team to explicitly define what he should observe and what staff should be able to explain about the supports to be provided.<br><br><u>Pre-Move Site Visit Completed by Facility:</u><br>The Post-Move Monitor was reported to be generally responsible for completing 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 14 individuals who had transitioned in the past six months. For the 14 individuals, a Pre-Move Site Review was conducted by the Facility for 14 (100%).<br>• Fourteen of 14 (100%) were completed on a timely basis.<br>• Fourteen of 14 (100%) included a visit to each service provision site.<br>• 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.<br>• 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. Only one of 14 (7%) called for staff interviews related to any supports, but there was no specific documentation even in that one that described what the staff interviews were to include. Otherwise, only observations of the completed in-service materials and signature sheets were requested. 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. | |

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| | | LA Continuity of Care Process:<br>The Monitoring Team reviewed documentation for 14 individuals who had transitioned to the community in the last six months and found that for 14 of 14 (100%) the LA Continuity of Care Pre-Move Site Review Instruments was completed within the required timeframe.<br><br>Coordination of CLDP with provider staff:<br>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.<br><br>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 an area of focus/priority for the next six months:<br>Assess and develop a corrective action plan related 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. | Quality Assurance Processes to Ensure Development and Implementation of CLDPs:<br>At the time of the last monitoring visit, the Facility had 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. During this monitoring visit, the Facility reported DADS state office had recently issued a CLDP monitoring tool that would take precedence. This version had not yet been implemented, but was to begin in February 2014. The tool was designed to incorporate monitoring from the development of the CLDP through PMM activities.<br><br>The Facility continued to implement two additional practices related to enhancing the quality of transition planning for individuals who had been referred. These included:<br>• 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 | Noncompliance |

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| | | 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.<br>• 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 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. Each of the Pre-Move Site Reviews reviewed indicated this had been completed.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. | |
| T1g | Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to | <u>Facility Annual Obstacles Report:</u><br>The Facility provided an updated Annual Report: Obstacles to Community Referral and Transition, Fiscal Year 2013 for review. The report was dated November 2013. The Facility identified center strategies and actions to overcome or reduce obstacles to referrals and transition to the community. Primary obstacles to referral included individuals' reluctance and LAR reluctance. The Facility described strategies it has been implementing this past year and further ascribed its significant increase in the number of referrals to these strategies. Additional plans were not deemed necessary at this time. Obstacles to transition were also identified, with the highest number related to lack of availability of specialized medical supports, followed by Individual/LAR indecision. DSSLC provided valuable discussion about its efforts to work with LARs and individuals throughout the process as obstacles arise. It did not provide any specific strategies being implemented to address the lack of available specialized medical supports.<br><br><u>DADS Annual Obstacles Report:</u><br>A new comprehensive DADS annual report had not yet been issued. It was reported DADS was currently reviewing the updated 2013 DSSLC Report referenced above, along with those from the other SSLCs.<br><br>DADS had previously 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 | Noncompliance |

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| | be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature. | following summarizes some positive aspects of the report:<br>• 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.<br>• There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred.<br>• 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).<br>• The report included attachments with each of the Facilities' annual reports.<br><br>The following concerns were noted with regard to the report:<br>• <u>Definitions</u>: 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.<br>• <u>Referrals</u>: 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.<br>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 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. | |

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| | | • 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.<br>• 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.<br>• 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.<br>• 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…"<br>• 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 assistance from other state agencies (e.g., DARS).<br><br>Conclusion: This provision was found to be not in compliance. | |

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| 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 (CPR), dated Monday, January 13, 2014 for Meeting Dates 7/15/2013-1/13/2014. It included the following information as further detailed in T1a:<br>• Number and names of individuals placed in the community<br>• Number and names of individuals on active referral list<br>• Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference<br><br>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 to Their Needs** | | |
| T2a | Commencing within six months of the Effective Date hereof and with full implementation within two | Policies and Procedures related to Post-Move Monitoring:<br>The Facility reported it was using the PMM Checklist revised in May 2013. This Checklist was condensed from the previous version and closely resembled an earlier document. | Noncompliance |

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| | 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. | Staffing:<br>There was a single Post-Move Monitoring position at the time of the monitoring visit. A change in staffing for this position had occurred since the last monitoring period, but any potential disruption appeared to have been minimized by the selection of a former Director of CFR to fill this crucial post. In addition, the Facility had recently hired a Master's level Social Worker to assist with both transitions and post-move monitoring. The Facility was to be commended for providing sufficient resources to meet the additional demands resulting from its relatively high number of referrals and transitions.<br><br>Review of PMM Checklists:<br>The Monitoring Team reviewed PMM Checklists for 22 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:<br>• Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner. For 22 individuals, 41 reviews should have been completed since the previous review. Of the 41 required visits, documentation and staff report indicated 41 (100%) were conducted and 41 (100%) were completed on time. Twelve of the PMM visits had occurred shortly before the monitoring visit, such that the Checklists were not yet available for review.<br>• 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).<br>• Use of Standard Assessment Tool: For the 29 PMM visits conducted for which documentation was currently available, 29 (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.<br><br>Assessment of Presence of Supports Called for in CLDP:<br>The Monitoring Team also reviewed a sample of PMM Checklists for five individuals (Individuals #20, #133, #359, #306, and #444) more extensively to evaluate the process for assessing the presence of supports as well as efforts undertaken by the Facility to ensure implementation of the supports. The PMM Checklists for five of five individuals (100%) reviewed appeared to include a verification that each support was in 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 | |

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| | | documented follow-up and loop closure. However, the failure of the IDTs to adequately describe the full set of supports, services and protections needed and the specific evidence required to verify their presence made it difficult to perform an accurate assessment using only the paperwork. The findings in Provisions T1e and T1d above also call into question whether supports are being accurately assessed.<br><br><u>Facility's Efforts to Ensure Supports are Implemented:</u><br>There were examples in which the Facility did act to ensure appropriate supports were implemented as required. For example, as documented in the previous monitoring report, Individual #359 had had a significant weight loss over the year preceding his transition to the community. 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 at that time to determine if there were any underlying causes for the weight loss. The Monitoring Team brought this to the attention of the Facility. At the time of this monitoring visit, the Monitoring Team requested the complete PMM file for Individual #359, including all correspondence and training, to evaluate the appropriateness of the actions taken by the Facility to follow up on this issue. The Facility had continued to monitor the individual's weight, which had remained stable throughout the 90 day PMM period.<br><br>However, the Monitoring Team found evidence in the documentation provided that the Facility did not yet consistently take assertive action on a continuing basis to ensure supports were implemented. Examples included:<br>• For Individual #359, the PMM file did not provide evidence of adequate efforts to ensure all supports were implemented. Required supports included that the individual be seen by an Occupational Therapist, a Physical Therapist, Speech Therapist and a neurologist within 60 days of the transition date, but none of these had occurred at the time of the 90 Day PMM visit. The Facility provided no documentation of follow-up efforts to ensure these had occurred between 45 and 90 days. The 90-Day PMM Checklist, completed on 8/29/13, indicated follow up was to be completed for the completion of these supports. No evidence was provided in the completed PMM file that this follow-up had indeed occurred. 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 | |

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| | | 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 were to sign off upon completion of the follow-up action. This section of the 90-DayPMM Checklist for Individual #359 was signed on 9-5-13 by the Post Move Monitor and the APC, but no follow-up was documented, indicating this formal process still allowed for the completion of important supports to fall through the cracks on occasion.<br>• The Monitoring Team also reviewed the PMM Checklists for Individual #133, whose 7-Day PMM visit had been observed during the previous monitoring period. A number of concerns had been raised regarding the Facility's transition processes at that time. It did appear that many of the concerns had received attention during the ensuing PMM visits. Additional concerns had arisen during the time between the 7-Day and the 45 and 90 Day visits that called for the Facility to provide increased vigilance, however. The individual had been hospitalized for Tegretol toxicity for three days on September 10, 2013, approximately one month before the 90-Day PMM visit to the home on October 11, 2013. There was very little information provided as to the details of this hospitalization and none regarding the actions to be taken to prevent recurrence. This was of particular importance because the individual's original transition had been delayed due to a hospitalization for a similar issue. It was also noted by the Post Move Monitor that the individual had lost nine pounds between 8/21/2013 and 10/10/2013. The Post Move Monitor attributed the weight loss as likely being due to the hospitalization and noted that staff reported the individual's eating habits had recently returned to baseline. However, the most recent weight indicated a continued downward trend, including two pound weight loss from the week before the 90-Day PMM visit. There was no follow-up plan indicated nor was there any documentation of consideration for extending the PMM period in order to ensure the situation had stabilized. There was also no evidence provided that the individual's IDT at DSSLC had reviewed the findings and provided input. See below regarding the extent of IDT review of PMM visits.<br>• The Monitoring Team reviewed the PMM Checklists and other documentation for Individual #306, who had significant behavioral health needs. The Facility had indicated the follow-up for this individual was an example of going above and beyond the minimum requirements for PMM in order to ensure the transition was successful. The individual had transitioned on 10/16/2013 and the Facility had maintained contact with the provider beyond the minimum 7, 45 and 90 day requirements to offer assistance. The Facility had also held an IDT review on 12/10/2013 for an incident that occurred on 12/4/2013 in which the police were called to respond to a behavioral crisis. This incident was not reflected in the list of Potentially Disrupted Community Transitions provided to | |

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| | | the Monitoring Team for review, which was to have included all such disruptions through 12/18/2013. The documentation indicated the individual was handcuffed as well as transported to a hospital in restraints. The IDT made four recommendations as a result of its review, including the following:<br>o Follow-up with previous counselor on how the individual's coping skills cards were made and provide the provider with the information.<br>o DSSLC will provide transportation for Facility preferred staff to visit the individual.<br>o DSSLC staff will make calls to the individual to provide support<br>o Will provide support to the provider upon the provider's request.<br><br>On 1/16/2014, the Monitoring Team requested documentation of the follow-up the Facility had taken on these recommendations, which were designed to support the individual and provider staff in order to prevent a failed transition. The Facility provided an email from the QIDP of the individual's IDT with the following information:<br>o DSSLC followed up with the previous Counselor on 1/16/14 to inquire about "Coping Skills" cards.<br>o DSSLC contacted the provider via phone on 1/16/14. There was no answer and contact would be attempted on following day.<br>o The previous QIDP did not follow up to schedule a familiar staff to go and visit the individual.<br>o The previous QIDP did not follow up to have a familiar staff contact the individual via phone.<br>o The current QIDP will make contact on Tuesday 1/21/14 about scheduling a visit for staff from DSSLC to visit with the individual.<br>o The current QIDP will also inquire on Tuesday, 1/21/14 what would be the best time for staff/peers from DSSLC to contact the individual via phone.<br>It was a positive step for the IDT to meet and develop recommendations to assist this individual and provider, but no actions had been taken for over a month to implement any of the recommendations until the Monitoring Team requested the information. Given the individual's needs and the serious nature of the incident, requiring police intervention, restraints and transport to the hospital, action should have been taken immediately.<br><br><u>ISPA meetings following PMM visits</u>:<br>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 | |

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| | | relied primarily upon the Post-Move Monitor, perhaps in consultation with other Department of CFR staff, to identify such a need. It was reported the Facility had begun to require IDT review of the 90-Day PMM Checklist at a minimum, but this was a recent decision. The only documentation of IDT review of any PMM activity provided was for the potentially disrupted transition for Individual #306 described immediately above. While it was positive the IDT met to complete this review, the Facility failed to act on the recommendations.<br><br><u>Barriers to thorough PMM Review and Improvements Needed in Monitoring:</u><br>The IDTs still did not yet provide adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of essential and non-essential supports. For example, in some instances the IDTs continued to indicate the evidence required to verify essential supports related to training were to be a training roster and the training materials. The IDT should also clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster. When staff interview is indicated, the IDT must also provide some criteria for the Post-Move Monitor to use in assessing whether provider staff have adequate knowledge of the specific supports.<br><br><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 remained at this time. | |
| 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><br>The Monitoring Team accompanied the Post-Move Monitor on the home visit portion of the 7-Day PMM for Individual #726. The PMM visit to the day program site had been done earlier in the day. The CLDP and accompanying assessments were also reviewed<br><br>The Monitoring Team found there was progress in the rigor with which the PMM visit was completed. The Post-Move Monitor checked each item on the list of supports. In most cases, this was done through visual observation; when a support involved training staff, the post-move monitor asked the provider staff how she did certain things that should have been trained, such as how she assisted the individual to move around the house. These questions were asked in a conversational manner; after the visit, the post-move monitor explained which questions he asked and how these tested for specific supports listed; a positive finding was that the post-move monitor did not ask the provider staff only whether she had been trained, but asked questions that would provide evidence of whether the staff knew the information that had been trained. The Monitoring Team checked each item on the list of supports by observing what the post-move monitor observed and by listening to the post-move monitor's conversations with | Noncompliance |

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| | | the provider staff when possible to do so unobtrusively. Between those observations and discussion with the post-move monitor following the visit, the Monitoring Team was able to determine that each support to be provided at the home and due by the end of seven days had been checked.<br><br>It was noted; however, that the CLDP indicated in some instances that staff interview would be required as evidence, but did not provide specific criteria for what the interview should be expected to include or what outcomes regarding staff knowledge were to be assessed. For example, one post move support called for the provider to monitor and record five target behaviors. The evidence required was listed as "Behavioral data sheets from home and day hab, staff interview." There was no indication of what the IDT intended to be included in the interview. It was therefore not possible for the Monitoring Team to fully assess whether the PMM process would produce the information needed to ensure supports for this individual were implemented as needed to facilitate a successful transition.<br><br>In addition to Individual #726, another individual who have moved from DSSLC to that home was also present during this PMM visit. Although this visit was in between scheduled post-move monitoring visits for this other individual, the Post-Move Monitor checked that supports remained in place. This was a very positive practice, which the Monitoring Team commends.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team found no apparent deficiencies in the monitoring process during this particular PMM visit and was impressed with diligence of the Post-Move Monitor. Deficiencies in the overall process of PMM remained, however, resulting from a lack of adequate detail in the CLDP, as described in Provision T1e and lack of appropriate and needed follow-up as described in Provision T2a. As a result, it was not possible to conclude this provision was 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:<br>• 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.<br>• 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. | |

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| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations. | | |
| **T4** | **Alternate Discharges -** | | |
| | Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days; | <u>Number and Categories of Alternate Discharges:</u><br>The Facility reported one alternate discharge had occurred since the last on-site review, which involved a transition to another SSLC.<br><br><u>Compliance with CMS-required Discharge Planning Procedures:</u><br>A review was conducted of the alternate discharge packet for Individual #119 to determine whether or not the Facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below:<br>• If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause. Based on the information provided, good cause was identified in the discharge summary.<br>• The Facility provided a reasonable time to prepare the individual and parents or guardian for the transfer or discharge (except in emergencies): Based on the information provided, it would appear reasonable time was given to prepare.<br>• At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: The final summary included each of these components, but the information was not always adequate. In the most concerning deficit, the individual had | Noncompliance |

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| | (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | experienced a fall in September 2013 and required a laminectomy and a discectomy, which was noted in the discharge summary. It was not noted that he also had a T4-T10 fusion, although this information could be found in the nursing assessment completed in November 2013 for the annual ISP planning meeting. No details as to the individual's post-hospitalization needs were included in the summary.<br>• The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT did not adequately describe the key supports that the individual would need in the new setting. As noted above, the individual had required back surgery in September 2013. The Annual ISP planning meeting Narrative, dated 11/05/2013, noted that the individual was to be seen by the neurosurgeon on December 5, 2013 at which time continuing needs for mobility supports would be evaluated. The Discharge Summary and Post Discharge Plan of Care did not reference the findings of this visit, nor were any of the accompanying nursing, physician or OT/PT assessments updated since that time. Overall, the Discharge Summary and Post Discharge Plan of Care did not provide adequate information to ensure the individual's needs in this area could be properly evaluated in the new environment. While the Facility did provide the receiving facility with the recent ISP and assessments, the individual had very significant medical and complex behavioral health needs which were inadequately summarized in the narrative and inadequately reflected in the Post Discharge Plan of Care, which was limited to the following:<br>o Family contact<br>o Smoking schedule<br>o Psychiatric and psychological services<br>o Counseling (preferably DBT) to improve problem solving skills<br>o Increased level of supervision<br>• With the consent of the individual, parents (if the client is a minor) or legal guardian, the Facility provides a copy to authorized persons and agencies: Although it would be expected the Facility provided a copy of the discharge summary and related assessments to the receiving Facility, there was no explicit documentation to show that this had occurred.<br><br><u>Conclusion:</u> This provision was found to be not in compliance. A discharge plan sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement was not provided. | |

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated 12/27/2013<br>2. DSSLC Action Plan for 12/5/13<br>3. Denton State Supported Living Center Report for Monitors<br>4. Section U Presentation Book materials<br>5. DADS Policy 019: Guardianship, effective 3/7/2012<br>6. DADS Policy 057: Self-Advocacy, effective 05/30/12 with revision<br>7. DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012<br>8. DSSLC Policy CMGMT 40: Advocate, effective 05/15/2012<br>9. DSSLC Policy CMGMT 41: Self-Advocacy, revised 12/12/13<br>10. DSSLC Policy G13: Volunteers, revised 11/01/2013<br>11. Rights Assessment, Form 6614, dated September 2011<br>12. Annual ISPs and Completed Rights Assessments for Individuals #4, #26, #177, #221, #311, #376, #408, #565, #608 and #564<br>13. Integrated ISP Monitoring Tool<br>14. Section U Guide for Using ISP Monitoring Tool<br>15. Guardianship Committee Minutes for the past six months<br>16. Self-Advocacy Minutes for the past six months<br>17. 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 December 2013<br>18. Since the last review, a list of individuals for whom an LAR or advocate has been obtained<br>19. Over the six (6) months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates<br>20. Guardian Specialists Monthly Updates on Individuals on Priority List & Preliminary Priority List for the last six months<br>21. Denton State Supported Living Center QA/QI Council Meeting: Data Analysis Report, including Section U, dated August 23, 2013<br>**People Interviewed:**<br>1. Pam Garrett and Sezer Ruzek, Human Rights Officers (HROs)<br>2. Lori Powell, Director of Quality Assurance (QA)<br>**Meeting Attended/Observations:**<br>1. Annual ISP meetings for Individuals #228 and #567<br>2. ISP Preparation meeting for Individual #182 |
| | **Facility Self-Assessment:**<br>The Facility submitted a Self-Assessment for Section U. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section U, in conducting its self-assessment, the Facility did not present data derived from the the Integrated ISP Monitoring Tool which was routinely used to evaluate, among other things, how the teams were using the rights assessment as well as to measure the outcomes. |

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| | The Facility did provide some data from processes completed for the Self-Assessment, but these were not from the Facility QA/QI system. It was reported that the QA office was not always integrally involved in the Self-Assessment process. For purposes of validity, sustainability and continuous improvement, it will be essential that the Facility's ongoing internal QA processes are the basis for the Self-Assessment in the future.<br><br>The data provided in the Self-Assessment tended to be somewhat imprecise and not outcome oriented. For example, the Facility reported it had reviewed ten ISPs to ensure IDTs discussed several items as they related to the individual's ability to render a decision, including the individual's intellectual level of disability, psychiatric conditions and the individual's capacity to communicate. The reported results were that 10 out of 10 rights assessments reviewed revealed that the teams are discussing and documenting individuals' ability to make decisions/ to provide informed consent. These data did not address the quality of those discussions or whether they led to any action plans to incorporate individuals' input into their daily lives.<br><br>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 promising Action Steps reported as being in progress, including increasing implementation of formal training in decision making/ choice making for selected individuals in Self Advocacy Group, which was also expected to provide data for evaluating the impact of this training on the capacity of individuals to make informed choices; implementing a "Supportive Friendship Program;" and developing a meaningful training for incorporating individuals' input into their everyday lives. Actions described to ensure a standardized and valid tool, process, or methodology for assessment of decisional capacity were reported to have been not yet started. This remained the primary need for the Facility to achieve compliance with the requirements of this section.<br><br>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. Sections of the Self-Assessment did not reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together. 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.<br><br>Overall, the Facility rated itself as being not in compliance with the following provisions of Section U: Provision U1 and U2. The Monitoring Team concurred. |
| | **Summary of Monitor's Assessment:**<br>This Section was not yet in compliance. A summary of noted progress included the Facility's continued innovative approaches in developing of alternatives to guardianship such as its Advocacy and Supportive Friendship programs. The Monitoring Team also commends the Facility for its initiative in incorporating |

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| | formal choice and decision-making training in its self-advocacy efforts. Overall, the Facility had put into place a number of systems that will be important underpinnings once the Facility has developed the capacity to assess individuals' needs for guardianship and other decision-making supports. Other specific findings for each provision are as follows:<br><br>**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 (Integrated Risk Rating) 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 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 assessment process, tool and/or methodology in place to determine the actual need for guardianship. It was reported that such guidance was forthcoming in the near future.<br><br>**Provision U2:** This provision was found to be not in compliance. The Facility continued to implement its Guardianship Committee in a thoughtful and organized manner, as called for in the DADS Policy. The Facility had made adjustments to its Advocacy program in response to a ruling from DADS that employees not be assigned as official advocates, including implementation of a Supportive Friendship program. The Monitoring Team also commends the Facility for its continuing initiative toward incorporating formal choice and decision-making training in its self-advocacy efforts. It was reported nine guardians had been obtained since the last monitoring visit. Of the 496 individuals residing at DSSLC, 132 did not have a current guardian. As noted above, the Facility's efforts reflect a solid system for assisting individuals to obtain decision-making supports, but the Facility continued to need to ensure it has an appropriate methodology in place to determine the actual need for guardianship or other supports before such decisions can be appropriately made. |

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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 | <u>Policies And Procedures Related To Functional Capacity To Give Consent And/Nor Need For LAR:</u><br>No new DADS policies or procedures 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 | Noncompliance |

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| | 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. | how this assessment should be accomplished. The policy did not address the standardized process, methodology, or tools IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. The Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed.<br><br>It was reported by the HROs that a revamped Rights Assessment, currently in draft development by DADS State Office, was expected to be issued in the near future. It was anticipated this tool would be used to guide the IDTs in determining decisional capacity. The draft was not currently available for review.<br><br><u>Maintenance of Prioritized List:</u><br>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:<br>• <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 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 again commends the creativity and initiative of the Facility in attempting to obtain objective and individualized information on which to base decisions regarding priority needs for decision-making assistance. As the IDTs improve their abilities in evaluating risk in the IRR process, these data will likely become more reliable for use in the prioritization process.<br><br>The list was complemented with a list of individuals' current guardianship status. This allowed the Facility to have a single master database regarding guardianship. The Monitoring Team reviewed the Priority List provided in the Section U Presentation Book, dated Monday, December 09, 2013. There were seven names on the list, all of whom had been determined to have the most significant need for assistance in decision-making according to the prioritization | |

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| | | process described above. Another 107 individuals without a current guardian were included in the Preliminary Priority List, dated Monday, December 30, 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 in December 2013 (day not legible), included 18 individuals.<br>• 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 determined by the Guardianship Committee. As successor guardians were obtained, individuals were also removed from that list.<br><br>Assessment of Functional Capacity to Render a Decision:<br>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 QIDP meeting for training in discussion and documentation of the rights assessment and integrating individuals' input to everyday lives to increase decision making. The HROs also attended 18 ISP annual planning meetings between August and November 2013 to provide technical assistance to the IDTs and engage in quality monitoring.<br><br>Overall, 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 ten individuals, with the following findings:<br>• For none of the ten reviewed (0%), did the IDT conclude the individual was able to give, or substantially participate in giving, informed consent in any of the seven areas listed.<br>• In four of ten (40%) 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.<br>• 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 | |

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| | | sufficiently implemented by the IDTs. There continued to be instances in which the IDTs described the types of input a person could have, but these were not incorporated into corresponding actions or instructions within the ISP that would facilitate such input taking place.<br>• For one of the ten Rights Assessments (10%) 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.<br><br><u>Conclusion:</u><br>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 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, methodology, and/or tool rooted in objective evidence-based principles of decisional capacity, and further, require 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><br>• 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. The local policy, DSSLC Policy CMGT 30: Guardianship, dated January 16, 2012, also remained in effect.<br>• DADS Policy 057: Self-Advocacy, dated 5/30/12, was reported to have been modified in content related to the section on Focus of Meetings, although a revision date was not indicated. The DSSLC Policy CMGMT 41 on Self Advocacy had been revised on 12/12/13 to incorporate the Focus of Meetings section in the DADS policy by reference.<br>• A DADS policy on Advocacy had not yet been issued, but DADS State Office had provided guidance to the facilities to cease allowing employees to serve as advocates, regardless of any provisions in place to avoid potential conflicts of interest. The Facility had taken action to implement this directive as discussed further below, but was awaiting the issuance of the final DADS policy before revising the local DSSLC Policy CMGMT 40: Advocate, effective 05/15/2012.<br>• The Facility had revised its local DSSLC Policy G13: Volunteers, dated 11/01/2013, to clarify the requirements related to employees serving as Volunteers; for example, employees may not volunteer in their assigned work area nor perform duties for which they are usually paid except as specified. | Noncompliance |

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| | | An employee who has a long-standing, supportive relationship with an individual who receives services may volunteer with that person in certain situations that are specified in the policy. The revision was undertaken in response to DADS guidance that staff may not serve as official advocates<br><br>Facility Efforts to Obtain LARs:<br>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 recommendations for action and track progress. The Facility reported that nine LARs had been obtained for individuals living at DSSLC during past six months. Each had been reviewed through the Facility's Guardianship Committee consistent with policy. The HROs also reported they were continuing to follow-up on expiring guardianships to assure continuity as well as providing education to current LARs and families about planning for successor guardians. Of the nine guardianships obtained, five were new, including three from the Priority List, and four were successor guardianships.<br><br>Membership of the Guardianship Committee was consistent with both statewide and local policy requirements. The members reviewed requests from IDTs for consideration for guardianship or advocate assignment. Committee members also reviewed the priority list and progress notes for each individual on the priority list on a monthly basis to address any changes as needed and progress towards guardianship and recommended action steps for each individual. In addition, training and informational presentations were provided to the Committee on an ongoing basis at most meetings, as described in the previous monitoring report. The HROs continued to complete a comprehensive monthly status summary of individuals referred to the Guardianship Committee for either a guardian or advocate and provided a review of this report in the meeting.<br><br>Other organized efforts toward obtaining LARs as well as other appropriate decision-making supports for individuals included:<br>• Advocacy Program: The Facility continued to implement its Advocacy Program. As noted, since the previous monitoring visit, DADS had issued a directive to the SSLCs to cease allowing employees to serve as advocates, regardless of any provisions in place to avoid potential conflicts of interest. As DSSLC had relied almost exclusively on its existing staff to take advantage of their having already been through a background check, this required an overhaul of the Advocacy program. The HROs received permission from DADS state office to implement a Supportive Friendship program and revised its local DSSLC Policy G13: Volunteers, dated 11/01/2013 to clarify the requirements as described above.<br>• Self-Advocacy Program: The HROs continued to provide support for the Self- | |

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| | | Advocacy Committee. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit. There continued to be an emphasis placed on informed choice and consent over this time period. This included the continued implementation of a formal choice-making curriculum obtained from another state developmental disabilities agency. The HROs provided training using these "Making Informed Choices" materials at three Self-Advocacy meetings in August, September and October 2013.<br>• Other Activities of the Guardianship Coordinators: The HROs continued to be very actively engaged in other activities related to obtaining guardians and advocates. In addition to those described throughout this section, the HROs also attended a three day Consumer Rights Conference and training in Austin in October 2013.<br><br>Overall, the Facility had good processes and systems in place to assist individuals who may need guardians, and these will be important underpinnings once the Facility has developed the capacity to assess individuals' needs for guardianship and other decision-making supports.<br><br>Quality Assurance Processes:<br>The Facility continued to implement a quality assurance process for this Section, which the Monitoring Team commends, but it was not clear the Integrated ISP Monitoring Tool process was generating meaningful data or being used to assess progress for this section. The Denton State Supported Living Center QA/QI Council Meeting: Data Analysis Report, including Section U, dated August 23, 2013 indicated that IDTs were found to be discussing input individuals could provide in decision-making 56.5% of the time. This discussion was captured in the ISP document only 11.8% of the time. These data were inconsistent with the Self-Assessment which reported that that 10 out of 10 (100%) rights assessments reviewed revealed that the teams are discussing and documenting individuals' ability to make decisions/ to provide informed consent. The same inconsistency was present within the QA/QI report; despite the data provided, the Data Analysis for Section U stated IDTs "were are discussing 'input' from the individuals related to informed consent and decision making in each area during discussion of individuals rights assessment to enhance individual's participation to decision making."<br><br>The ISP Monitoring Tool did not address whether IDTs were developing Action Plans related to enhancing decision-making input or integrating individuals' abilities to provide input into other components of services and supports. The Section U Guide for Using the ISP Integrated Monitoring Tool provided in the Section E Presentation Book also instructed that the question as to whether the IDT used a capacity assessment in | |

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| | | making determinations about informed consent was no longer applicable and data were not being collected. The Facility will need to consider revisions to its QA/QI processes as the pending capacity assessment process, tool, or methodology is rolled out in order to ensure appropriate outcome measures are in use.<br><br><u>Conclusion:</u><br>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, methodology, 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. The QA/QI processes should also be revised to ensure appropriate outcome measures are in use. | |

| SECTION V: Recordkeeping and General Plan Implementation | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Self-Assessment 12/27/13<br>2. DSSLC Action Plan for 12/5/13<br>3. Presentation Book for Section V<br>4. Provision Action Information<br>5. DADS Policy 020.1 Recordkeeping Practices 3/05/10<br>6. DSSLC Policy CM-25 Recordkeeping Practices 2/6/13<br>7. DADS Policies revised since last visit<br>a. DADS Policy 002 Incident Management 11/5/13<br>b. DADS Policy 004 ISP Policy 11/21/13<br>c. DADS Policy 008 Behavioral Health Services Department 11/5/13<br>d. DADS Policy 015.1 Dental Services 8/15/13<br>e. DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition 8/1/13<br>f. DADS Policy 018.2 Most Integrated Setting Practices 10/18/13<br>g. DADS Policy 021.3 Protection from Harms-Abuse, Neglect, and Exploitation 11/13/13 (in DSSC Policy as CMGMT 01A)<br>8. DSSLC Policies revised since last visit<br>a. General 10 Infection Prevention and Control (and Exhibits) 10/22/13<br>b. General 13 Volunteers 11/1/13<br>c. Comm/Councils 04 Physical Nutritional Management Committee 10/1/13<br>d. Client Mgmt 03 Integration of Clinical Services 12/1/13<br>e. Client Mgmt 12A Habilitative, training, Education, and Skill Acquisition Programs 11/1/13<br>f. Client Mgmt 23 Communication Policy 10/1/13<br>g. Client Mgmt 32 Physical Nutritional Management 10/4/13<br>9. Active Record Order & Guidelines 10/25/13<br>10. Master Record Purging Schedule 10/15/13<br>11. Individual Notebook & Guidelines—Extension of the Active Record 9/18/13<br>12. Active Record Order & Guidelines Audit Tool 12/11/13<br>13. Individual Notebook & Guidelines Record Audit Tool 12/11/13<br>14. Record Audits, including emails regarding corrective actions for 15 audits conducted September, October, and November 2013, for Individuals #83, #132, #182, #333, #402, #427, #449, #457, #487, #526. #563, #694, #747, #743, and #787. 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 Order & Guidelines Audit tool, and emails listing corrective actions needed<br>15. Quarterly data report for Section V of 11/19/13 with data through October 2013<br>16. Updated data including record audit error trends<br>17. Active Record, Individual Notebook, and Master Record for Individual #800 |

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| | 18. Active Record and Individual Notebook for Individual #413<br>19. Active Record, Individual Notebook, and list of audit deficiencies needed correction and corrected for Individual #457<br>20. Description of how the Facility monitors to determine whether assessments have been completed and filed<br>21. Compliance by Unit and Individual—Annual Assessments Filed 10 Days Prior to PSP 11/1/13-11/30/13<br>22. ISP Assessment Data by Apt-Unit table and graphs (various date ranges)<br>23. Share Drive information on assessments for Individual #299<br>24. ISP Monitoring Tool<br>25. Email from Sara O'Bryan of 8/19/13 notifying of addition of question to the ISP monitoring tool<br>26. DSSLC Monthly Audit Tracking database reports for July 2013-December 2013<br>27. Email from Melissia Steele of 10/22/13 containing corrections needed as indicated from the record audit for Individual #457<br>28. ISPs, assessments, and handouts for ISP annual planning meetings for Individuals #567 and #791<br>**People Interviewed:**<br>1. Joint Interview of Melissia Steele, Unified Records Coordinator (URC), Betsy Knight, Records Administrator, and Lori Powell, Director of Quality Assurance (QA), regarding recordkeeping<br>2. Lori Powell, Director of Quality Assurance, regarding policy development and implementation<br>3. Joint interview of Leslie Clark, QIDP Coordinator, Julie Kuester, QIDP Education, and QIDPs David Bailey and Maureshia Davis<br>**Meetings Attended/Observations:**<br>1. ISP Annual Planning Meetings for Individuals #567 and #791<br>2. ISP Preparation Meeting for Individual #487<br>3. Change of Status meeting for Individual #567 |
| | **Facility Self-Assessment:**<br>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.<br><br>For Section V, in conducting its self-assessment, the Facility:<br>▪ 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:<br>o The monitoring/audit tools the Facility used to conduct its self-assessment included: The monitoring/audit tools the Facility used to conduct its self-assessment included:<br>▪ The Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4<br>▪ Active Record Order & Maintenance Guidelines (AROG) Audit tool<br>▪ Individual Notebook & Guidelines—Extension of the Active Record audit form<br>▪ Interview questions for V4 |

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| | ▪ ISP Monitoring Tool<br>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.<br>o The monitoring tools included adequate methodologies, such as audits of records and observation of meetings with documentation of specified actions.<br>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.<br>o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results.<br>o The following staff/positions were responsible for completing the audit tools:<br>▪ For Section V records audits: Melissia Steele, Unified Records Coordinator, and Records Clerks<br>▪ For the ISP Monitoring Tool, Sarah O'Bryan, Program Auditor<br>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).<br>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.<br>▪ Used other relevant data sources and/or key indicators/outcome measures, including:<br>o Percent of provisions covered in either State or local policies<br>o Percent of corrections for deficiencies noted in record audits<br>o Percent of records with check out card<br>▪ The Facility generally presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment:<br>o Presented findings consistently based on specific, measurable indicators. However, rather than simply stating that 0% of records contained all required documents, the Facility should consider breaking this out to identify if there are specific kinds of documents that are frequently not contained in the record so that the Facility could take action to address the need for improvement.<br>o Consistently measured the quality as well as presence of items. However, the Facility should consider reviewing not only whether records had check out cards, but also whether the check out cards are being used accurately and consistently.<br>o The Self-assessment did not distinguish data collected by the QA Department versus the program/discipline.<br>▪ 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<br><br>The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance.<br>▪ Actions were reported as Completed, In Progress, or Not started. For Provision V3, the Action Plan provided a list titled Steps to Maintain Compliance but did not indicate status of those steps; they |

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| | all appeared to be ongoing actions that had already been through initial implementation.<br>▪ The Facility did not specifically identify areas of need/improvement to be addressed by actions.<br>▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. |
| | **Summary of Monitor's Assessment:**<br>The Facility maintained a unified record for each individual. Records were generally accessible to staff who needed them, although the checkout process to identify where records were when not at the living unit was not consistently followed. The Facility maintained the level of completeness and compliance with Appendix D requirements as found at the last compliance visit.<br><br>**Provision V1:** 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. Improvement was needed in meeting requirements of Appendix D. The checkout system was not used consistently.<br><br>**Provision V2:** Both DSSLC and DADS continued to develop and revise policies and procedures. The Facility had developed a crosswalk of policies against provisions of the Settlement Agreement for DADS policies and Facility policies, and reported 97% of provisions were addressed by at least one policy. This should help identify any further needs for policy development. A database was developed to track training on policies, but it needed revision, and tracking of training was being done by manual review of training sheets. The Facility did not have a process in place for routine and periodic review of policies. The director of QA reported that a matrix of policies is being developed and is now about three-quarters complete. When that is done, it will be reviewed to determine what revisions and additional policies are needed.<br><br>**Provision V3:** This provision continues to be in substantial compliance with requirements. The audit system is robust and comprehensive. At least five random audits are conducted each month, and these are supplemented with additional audits of specific items in the record. Reliability across auditors is adequate. Audit findings for individual records are sent to staff responsible for making corrections. The Facility has a system for tracking corrections; although nearly all cleared items had been corrected, the Facility needs to be cautious and ensure all cleared items have been corrected. In addition, the Facility should consider ways to check on those items for which the specific deficiencies cannot be corrected but for which training or reminders are provided, such as legibility, to determine whether they improve. The Facility has addressed some systemic issues with varying degrees of success.<br><br>**Provision V4:** Records are accessible to staff, including clinicians and others. Except for the need to improve timeliness of assessments, most documents in the record were current. However, improvement remains needed, as audits conducted by the Facility rated none of the audited records as meeting the standard for Current documents. Data were usually documented timely, although improvement was needed in skill acquisition program data. Staff could report that they used records in making decisions and |

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| | could describe examples, but observations at interdisciplinary planning meetings (both in Facility audits and by the Monitoring Team) indicated use of records and information from records was variable. |

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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. | Policies Governing Recordkeeping<br>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 not been revised since the last compliance visit.<br><br>The Facility Maintains a Unified Record for Each Individual<br>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 Individual #800 and the Active Record and Individual Notebook for Individual #413. In addition, the Monitoring Team reviewed the Facility record audits from September, October, and November 2013 to determine whether they reported the presence of all three required components.<br><br>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.<br><br>The Active Record was the primary document with information about the individual's current status and about the supports and services being provided. Active Records were filed in two, three, four, or (for some individuals with complex medical conditions) more binders (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.<br><br>The Individual Notebook (also known as the All About Me book) contained information needed by people providing daily service. The Individual Notebook was maintained at the residence. Information needed at day program and vocational services, such as Physical and Nutritional Management Plans (PNMPs) and Positive Behavior Support Programs (PBSPs) were kept in books at those locations; these were not considered part of the Unified Record. When documents needed to be updated, they were sent by email | Noncompliance |

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| | | to the day programs and vocational services; the Facility should develop a process to ensure that these replace older versions, and that the versions in these locations are the same as those in the Individual Notebooks at the residences.<br><br>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.<br><br>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 ##413 and #800; Monitoring Team audits found two of two (100%) audited records included an Active Record and Individual Notebook; for one of one individual checked by the Monitoring Team (100%), the Master Record was readily available. The Master Record included a checkout form for checking out the record and a form to document copies made of documents and provided to staff or others.<br><br>Audits of 15 records conducted by the Facility in September, October, and November 2013 found 15 (100%) had an Active Record, and Individual Notebook, and a Master Record. Facility trend reports documented each month that 100% of records included all three components.<br><br><u>Staffing and Responsibility for Filing in the Record</u><br>The Facility had staff assigned to oversee the Unified Record. The Facility had one Unified Records Coordinator (URC) working on recordkeeping 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. | |

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| | | Training of Staff on Documentation<br>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.<br><br>The URC and a Records Clerk provide training during orientation on Recordkeeping. This training covers the requirements of Appendix D, among other topics. The training materials remained the same, but the URC reported that plans are in place to revise training.<br><br>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.<br><br>The Facility had developed and had begun to pilot an audit form to follow up a sample of new employees. The Monitoring Team expects to review this at the next compliance visit.<br><br>Accessibility and Security of Records<br>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 508C, 524A, and 524D, reviewed the last 15 Facility audits, and reviewed the data provided for the data analysis report with data through October 2013 and updated data provided for the document request.<br><br>For three of three individuals checked (100%), the Individual Notebook was readily accessible.<br><br>For four of five individuals checked (80%), the Active Record was readily accessible. For Individual #413, only one of three charts in the Active Record was present. As noted below, the other two charts were found following a search.<br><br>Audits of 15 records conducted by the Facility in September, October, and November 2013 found 15 (100%) records were accessible.<br><br>In addition, reports from Monitoring Team members reviewing records for other sections of this report also indicated records were consistently accessible.<br><br>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 five individuals. The checkout book was present in four of five | |

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| | | apartments (80%). For three of four who had a checkout book available (75%), the checkout form was accurate; for Individuals #457 and #800, all records were present, and there were no checkouts without returns documented. For Individual #749, charts had been checked out and returned but not documented as checked back in. At apartment 524D, no checkout book could be found. For Individual #413, two of three charts in the Active Record were not at the apartment. Because the checkout book could not be found, staff did not know where these books were. The Building Coordinator was able to track these charts down; one was being used by a nurse at another apartment in the unit, and the other was still at the clinic following the individual's clinic appointment earlier in the day. However, had the Building Coordinator not been available, these charts would not have been found and would not have been accessible to staff who might have needed to find information or to document in them. Although this might have been an anomaly, because this unit had temporarily moved to a different building due to a maintenance problem, the move had occurred approximately three weeks prior to this compliance visit, and staff did not seem aware that a checkout book was needed.<br><br>The data analysis report provided a bar graph for Individual Notebook Security for August, September, and October 2013 by unit. Most units had two numbers, such as TH1 and TH2, one unit was labeled "Vacant" and had data for two months whereas HP2 had data for the third month, and the total number of units on the graph was 13. All bars showed 100% except October bars for GR2 and PR. HP1, which had been problematic at the last visit, was reported as 100% for all three months.<br><br><u>Accuracy and Completeness of Records</u><br>To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the Monitoring Team reviewed the complete Active Record for Individuals #413 and #800. Individual #800 was selected by computer randomization out of the admissions since the last compliance visit. Individual #413 was selected by computer randomization from among the individuals residing at the Facility. The Monitoring Team audited these records using the same audit tools used by the Facility--the Active Record Order & Guidelines Audit Tool and the Individual Notebook & Guidelines Record Audit Tool; for each audit tool, there was a column with a box for each document to indicate present, missing, or not applicable, and a column to "Check if Meets App. D Criteria" and circle if it did not. The Monitoring Team used the Section V monitoring tool (titled Settlement Agreement Cross Referenced with ICF-MR Standards, Section V) to rate whether the requirements of Appendix D were met. In addition, the Monitoring Team reviewed data from facility random audits of fifteen individuals' records conducted in September, October, and November 2013 and reviewed data from the Facility's trend reports.<br><br>Many documents are not applicable in each record. The Monitoring Team made an effort | |

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| | | 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.<br><br>Completeness of Records: For Individual #413, 68 documents were present in the Active Record, 16 required documents were not present, and 154 documents were not applicable (the Monitoring Team did not check two documents, one of which was on the Share Drive rather than hard copy). Therefore, 68 of 84 documents (81%) that should have been in the Active Record were found in it. In the Individual Notebook, 12 of 15 required documents (80%) were present, and 15 documents were not applicable. Facility audits aggregate the data from the Active Record and Individual Notebook. Aggregating these shows that 80 of 99 applicable documents were present (81%).<br><br>For Individual #800, 65 documents were present in the Active Record, 11 required documents were not present, and 164 documents were not applicable. Therefore, 65 of 76 documents that should have been in the Active Record (86%) were found in it. In the Individual Notebook, 12 of 13 required documents (92%) were present, and 17 documents were not applicable. In total, 77 of 89 applicable documents (87%) were present. Review of this individual's Master Record indicated required documents were present.<br><br>The percentages of documents found present in the Active Record and the Individual Notebook were nearly identical to those of the last compliance visit.<br><br>Consistency with Appendix D Requirements: Neither record met all requirements of Appendix D. In general, the records were neat, and it was usually easy to find documents. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable.<br><br>To assess whether Appendix D requirements were met, the Monitoring Team took two actions. For documents found in the Active Record, the percentage of required and present documents 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).<br>• For Individual #413, 63 of 68 present documents in the Active Record (93%) and nine of 15 present documents in the Individual Notebook (60%) met Appendix D requirements; in total, 72 of 83 present documents (87%) met Appendix D requirements. The Monitoring Team's audit using the Section V | |

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Monitoring Tool found 19 of 26 checked Appendix D items (73%) to be compliant.<br>
• For Individual #800, 59 of 65 present documents in the Active Record (91%) and nine of present 13 documents in the Individual Notebook (69%) met Appendix D requirements; in total, 68 of 78 present documents (87%) met Appendix D requirements. The Monitoring Team's audit using the Section V Monitoring Tool found 18 of 26 checked Appendix D items (69%) to be compliant.<br>
• On the Section V Monitoring Tool, "Complete" was marked noncompliant on both audits, as were "Entries are in reverse chronological order," "Signature with first/last name" and (Signature with "Title." 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 permit one missing document or page; more than one in the entire Active Record results in a finding that the record is not complete.<br><br>
Findings about the accuracy and completeness of records were very similar for all the above measures to those at the last compliance visit.<br><br>
Data from audits of 15 records showed percentages of compliance as shown in the table below:<br><br>
<table>
<tr><td></td><td>Range</td><td>Mean</td></tr>
<tr><td>Presence in Active Record and Individual Notebook</td><td>84%-95%</td><td>91%</td></tr>
<tr><td>Section V Monitoring Tool</td><td>77%-92%</td><td>84%</td></tr>
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<br>
These findings were somewhat higher than those found by the Monitoring Team.<br><br>
The Facility provided trends data for compliance with the Section V monitoring tool items.<br>
• The overall average of compliance on the Section V monitoring tool from November 2012 through October 2013 showed stable data with a slightly decreasing trend line. The range of compliance was from 73.9% in October 2013 to 96.6% in December 2012. These monthly data were calculated as the average of the questions identified in the bullet below. The questions have from one item (V4.1 and V4.2) to 16 items (V2). For October, question V4.2 compliance was not reported; as this was usually 100%, not including that in the average caused a decrease. Had it been reported and included in the average, the trend
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| | | line would show a much smaller downward trend.<br>• Data for the quarter were provided for questions V1.1 (whether all components of the unified record are maintained), V3.2 (compliance with Appendix D requirements, by requirement), V3.3 (security of the record), V3.4 (accuracy of recordkeeping), V4.1 (records indicate they are used), and V4.2 (staff interview indicates records are used). The unified record was maintained for 100% of records, and 100% of staff interviewed indicated use of the record. For Appendix D, 58% of requirements were rated as compliant. Eighty-five percent of records were secure, 67% were accurate, and 83% had documentation in the records that indicated they are used. Thus, the areas needing improvement were, for the most part, those involving accuracy and compliance with Appendix D requirements.<br><br>The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included:<br>• As documented in the last compliance report, DSSLC uses "Red Notebooks for DSPs" to provide instructions on health care plans rather than putting them in the Individual Notebooks. These notebooks contain Integrated Health Care Plans (IHCPs), DSP Instruction Sheets, and Acute Care Plans.<br>• Observation of the ISP annual planning meeting for Individual #567 found errors and lack of information in the record.<br>o The physician evaluation stated, although there had been hospitalization, "unable to find information in current records."<br>o Results of an EGC colonoscopy from October 2013 were not in the record for review, according to the OT/PT assessment dated 12/20/13 and 12/30/13.<br>• As reported in Provision M1<br>o Documentation errors were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed.<br>o Late entries were not consistently documented correctly.<br>o The time and/or dates of entries into the Integrated Progress Notes were not consistently included.<br>o The legibility of the nurses' handwriting had somewhat improved but the signatures and titles for some nurses continued to be illegible.<br><br><u>Use of Share Drive and Electronic Records</u><br>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 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 | |

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| | | Active Record are also posted to the Share Drive, including ISPs and ISPAs.<br><br>In addition, the Facility used the Avatar electronic records system for some documents. Since the last compliance visit, the Facility had begun to enter MOSES and DISCUS side effects scales into Avatar, and there is a plan to enter information on infections and to put integrated progress notes (IPNs) on Avatar.<br><br><u>Conclusion</u><br>The Facility maintained the level of completeness and compliance with Appendix D requirements as found at the last compliance visit. To move toward compliance with this provision, the Monitoring Team recommends the Facility consider:<br>• Establishing some form of audit of the checkout books to ensure they are available and are used accurately.<br>• Identifying Appendix D requirements needing improvement and establish corrective action plans (CAPs). The Facility reported three CAPs are in process. One CAP on timely filing of ISPs was initiated in September 2013. A workgroup has been established to work on legibility. A CAP is being initiated to reduce errors in filing at one unit. The Facility must track the effectiveness of these CAPs and revise them as needed.<br>• Providing some form of ongoing or refresher training to staff who document in the records and to their supervisors, department heads, and unit directors. This could be included both as part of CAPs and on a routine basis. Such training could be provided by the Quality Assurance department and/or by supervisors, department heads, and unit directors. | |
| V2 | Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | <u>Facility Process to Develop and Revise Policies</u><br>DSSLC Policy ADM 1-01 governed policy development; the process established in this policy was described in the last compliance report. At the last compliance visit, the Facility reported that the process for policy development and revision had changed, with the initiation of a policy committee to review drafts and to identify who needed training. In the interim, the policy committee did not meet regularly, and the former process was in effect. A policy writer drafts revisions or new policy and send those to the director of Quality Assurance (QA); the director of QA sends the draft to the committee members and the Executive Management Committee for feedback, revises the draft based on the feedback, and sends the final draft to the Facility Director for approval. This is an acceptable process, although the Facility should consider a process to ensure a review by a broad enough set of staff to identify issues that should be addressed.<br><br><u>Training on Policies</u><br>The Director of QA reported that the program writer proposes who should be trained; | Noncompliance |

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| | | the policy committee and the Executive Management Committee review and propose revisions, and the Facility Director provides final approval. However, at this time, the policy committee is not meeting regularly.<br><br>At the time of the last compliance visit, the Facility reported having put in place a database, merged with the employee database, to track training. Although the training database remains merged with the employee database, problems were found when revisions had to be made to the training database. The training database is being revised, and tracking of training is again being done by manual review of training sheets.<br><br><u>Development and Revision of</u> <u>Policies to Implement Part II of the Settlement Agreement</u><br>There is evidence that many policies, protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed; however, some essential policies, protocols and procedures remain to be developed and implemented.<br><br>In its Self-assessment, the Facility reported that 97% of Settlement Agreement provisions were covered in either State of local policies, with four provisions not covered. The director of QA reported that the Facility develops localized policies as needed to operationalize statewide policies; in some cases, the Facility adopts the statewide policy if there is no need to localize it. When reporting the percent of provisions covered, the self-assessment considered both local policies and State policies that had been adopted by the Facility. The Facility provided a two cross-walks of provisions with the covering policies, one for State Office policies and one for DSSLC policies. These crosswalks listed each provision and the policy or policies that addressed it as well as the page numbers of policy contents that addressed the specific provision. Doing this crosswalk by provision rather than by overall section is a positive step that will help the Facility ensure that all requirements of the Settlement Agreement are addressed as needed. The crosswalks also had a column for comments that included comments from compliance reports, concerns, and actions needed; this was a positive step that should provide the Facility and DADS with guidance as to revisions needed to policies.<br><br>The crosswalks verified that 97% of provisions are addressed by either State Office or Facility policy, or both. The quality of policies, any concerns regarding their content, and the status of implementation are addressed in the various sections of this compliance report. State Office and the Facility should use information from this report to identify revisions needed.<br><br>The State Office crosswalk identified provisions that did not have policy guidance. These included Provision G1, most provisions of Section H, Provision K13, Provisions O5-O8, and Provisions T3 and T4. It should be noted that this report finds, in Section U, that there remains a need for greater guidance on a systematic and effective process to | |

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| | | evaluate capacity to make decisions (a concern noted on the Facility crosswalk); the crosswalk identified that policies addressed both provisions of Section U.<br><br>The Facility crosswalk identified Facility policies that address Provision G1, all provisions of Section H, Provision O6, Provisions T3 and T4. The Facility also listed a number of other provisions for which there is no Facility policy that operationalizes and localizes State Office policy. These should be addressed as needed; if the policy can be implemented without localization, the Facility should adopt it into the policy manual. At the last compliance visit, the Facility informed the Monitoring Team that it is expected to include state policy in the policy manual and to draft an exhibit that operationalizes the policy to the Facility. The Facility did this for two new policies identified below. This would be a satisfactory way to ensure Facility policy is consistent with state policy and addresses provisions of the Settlement Agreement.<br><br>The Facility did not have a process in place for routine and periodic review of policies. The director of QA reported that a matrix of policies is being developed and is now about three-quarters complete. When that is done, it will be reviewed to determine what revisions and additional policies are needed. The crosswalk of Facility policies described above should assist in identifying not only policies that are needed but also revisions to address concerns and to ensure that the Facility addresses all provisions that need policy guidance.<br><br><u>New and Revised Policies:</u> The Facility and State had continued to develop and revise policies necessary to implement Part II of the Settlement Agreement since the last compliance visit.<br><br>New or revised DSSLC policies reported by the Facility included:<br>• General 10 Infection Prevention and Control (and Exhibits) 10/22/13<br>• General 13 Volunteers 11/1/13<br>• Comm/Councils 04 Physical Nutritional Management Committee 10/1/13<br>• Client Mgmt 03 Integration of Clinical Services 12/1/13<br>• Client Mgmt 12A Habilitative, training, Education, and Skill Acquisition Programs 11/1/13<br>• Client Mgmt 23 Communication Services Policy 10/1/13<br>• Client Mgmt 32 Physical Nutritional Management 10/4/13<br><br>New or revised DADS policies reported by the Facility and/or DADS included:<br>• DADS Policy 002 Incident Management 11/5/13 (in DSSLC policy as CMGMT 01B)<br>• DADS Policy 004 ISP Policy 11/21/13 | |

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| | | • DADS Policy 008 Behavioral Health Services Department 11/5/13<br>• DADS Policy 015.1 Dental Services 8/15/13<br>• DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition 8/1/13<br>• DADS Policy 018.2 Most Integrated Setting Practices 10/18/13<br>• DADS Policy 021.3 Protection from Harm-Abuse, Neglect, and Exploitation 11/13/13 (in DSSLC Policy as CMGMT 01A)<br><br>CMGMT01 and CMGMT 01A operationalized and localized many components of DADS policy, for example by identifying which staff positions were responsible for specific responsibilities.<br><br>In addition, as reported in Provision U2, the following policies had been revised:<br>• DSSLC Policy CMGMT 41: Self-Advocacy, revised 12/12/13<br>• DSSLC Policy G13: Volunteers, revised 11/01/2013<br><br>Many procedures have changed. Significant new or revised procedures included:<br>• DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, Date: September 2013<br>• DSSLC Nursing Protocol: Enteral Medication Administration, Revised: December 2013<br>• DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy – 27.1, Revised: 11/10/13<br><br><u>Examples of Policy Changes</u><br>In some cases, revisions to policies were minimal (although needed and appropriate), such as simply updating the names of assessments in DSSLC Policy CMGMT 03 Integration of Clinical Services. In other cases, revisions were more substantive. For example, as reported in Provision O1, 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, as well as adding processes and requirements. Several Sections of this report provide detail about policies that guide services at the Facility and about how accurately they are implemented.<br><br><u>Areas in Which Efforts Are Needed</u><br>Although, as noted above, both DADS and the Facility continue to develop and revise policies, some policies still need either to be developed or to be reviewed for possible revision. For example:<br>• The DADS Death Review Policy had not been updated. When the State Office 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 | |

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| | | death and to make systemic recommendations for care.<br>• The Facility should consider including in its Medical Care policy guidance on use of antibiotic biograms and expectations on frequency and comprehensiveness of follow-up for chronic medical conditions.<br>• As reported in Provision O7, the PNM policy (CMGMT 32-rev 10/4/13) 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 Facility should consider adding specific guidance.<br>• As reported in Provision Q1, the Facility's dental x-ray policy had not been updated, despite the dental director informing the Monitoring Team at the last compliance visit that the policy would be revised to reflect current dental standards with regard to the frequency of dental imaging.<br>• DADS policy addressing guardianship continues to need to provide more guidance to IDTs on assessing an individual's decisional capacities, and should address standardized process, methodology, or tools to assess and prioritize the need for assistance in decision-making. The Facility reported that DADS has draft revisions that are expected to be available in the near future.<br><br>It is most important that policies be implemented accurately. Several Sections of this report describe accurate implementation of policies. At the same time, there were examples described in several Sections of this report in which policies were present but were not being implemented consistently. For example"<br>• As reported in Provision L4, medical providers were not adhering to several requirements of the Facility's Medical Care policy.<br>• Completion of assessments, while improved, did not yet comply with requirements of policy.<br><br><u>Conclusion</u><br>In summary, the Facility has policies to cover most provisions of the Settlement Agreement; adoption and localization of some State Office policies should address nearly all provisions. Procedures for routine review and revision of policies are lacking. Although there are procedures for identifying who needs to be trained and the kind of training to be provided, the Facility needs to be clear on the role and process for involvement of the policy committee. There is no efficient way to ensure timely that all staff needing training have been trained. | |
| V3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement | <u>Audit Policy and Process</u><br>The Facility Recordkeeping Policy CMGMT-25 did not reference audits of records, and no other policy or written procedure was provided to the Monitoring Team. The Facility did have a process in place to audit five randomly selected records each month. The | Substantial Compliance |

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| | 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. | 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 of 15 records provided in response to the document request confirmed that both a records clerk and the URC audit each selected record.<br><br>Blank record audit forms included on them the definitions or guidelines to be followed in rating presence of documents or compliance with standards. Three tools were used, the 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 columns to record presence of documents and whether documents met Appendix D guidelines, and each of these were rated consistently.<br><br>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 hospitalization documents, which were now in the Share Drive) and of the Individual Notebook.<br><br>The audit included an item on the Section V Monitoring Tool 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 five disciplines to document IPNs as evidence this was occurring (a revision from requiring more than five, as noted in the last compliance report). The Facility counted several nursing staff as different disciplines (e.g., LVN, RN, and RN Case Manager); it might be better to count as separate disciplines only when there is a specialized duty (such as PNMT Nurse) or a different clinical discipline (which might necessitate reducing the number of disciplines required). In addition to audits of the records themselves, the Facility continued two processes to review whether the information from the records was being used in decision-making. 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.<br><br>The second process involved direct observation of IDT meetings and completion of a | |

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| | | checklist of items to be observed. Regarding use of records in ISP annual planning meetings, information from these audits is found in Provision V4.<br><br><u>Interobserver Agreement/Interrater Reliability</u><br>As noted above, the URC and records clerk audit a record. For the three months of audits reviewed, eight (53%) were dated the same day, 6 (40%) were dated one day apart, and one (7%) was dated two days apart. Although, to ensure the same documents are present in the record, it is best if the two auditors review the record on the same day, this timeliness of review across observers for a written record should be acceptable, and it is a significant improvement since the last review.<br><br>Per interview with the URC, these audits are conducted independently, without discussion prior to comparing the results.<br><br>Data on interrater reliability on the Section V Monitoring Tool was reported quarterly to the QA/QI Council. Monthly averages from July 2013 through October 2013 ranged from 81% in August to 85% in September. Although the trend over the past year was decreasing somewhat, it had been stable since the last compliance visit. At the last compliance visit, the Monitoring Team did a reliability audit with the URC and found acceptable agreement of 89%; because of this and the generally acceptable agreement between the Facility staff, the Monitoring Team did not audit a record with the URC at this visit.<br><br>The Facility did not report reliability data for the audit tools for the Active Record and Individual Notebook. However, the Facility showed the Monitoring Team audit information available on computer that shows agreement question by question on each audit; in addition, the Facility provided these lists for each month since the prior compliance visit. For September, the range of agreement was 79% to 90%, for October 76% to 86%, and for November 83% to 93%, with an overall average of 85%. This was not reported in the Trends Report but would be easy to include. Although overall agreement is acceptable, the Quality Assurance Department should review that information monthly and determine whether there are difficulties in rating whether any specific documents are present and meet Appendix D requirements; this would permit the Facility to determine whether the information would be useful for review by the QA/QI Committee and whether any specific improvements are needed. The Monitoring Team did not calculate reliability on the 15 audited records for September, October, and November 2013.<br><br>In addition to the random audits, the Records Clerks track whether ISPs needing to be filed are provided, whether Behavioral Services Progress Notes and QIDP monthly reviews are done, whether Skill Acquisition Plans (SAPs) are provided following the | |

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| | | annual ISP planning meeting, and whether Nursing quarterly assessments have been provided. They then put together the "D-list" of deficient items each Monday and Wednesday and send to all responsible disciplines. When the URC does a record audit, she also audits the current D-list for the individual and contacts the Records Clerk about any discrepancy. This information is also compiled for the QA/QI quarterly report.<br><br>Also, program auditors at the Facility have, as part of their audits of various aspects of program implementation and documentation, several questions that are also found on the Section V monitoring tool. The URC did reliability checks on these questions in October 2013; agreement data for these was included in the October reliability data. This is a good way to expand the scope of the audits using processes currently in place. The Monitoring Team will look more closely at this at the next compliance visit.<br><br><u>Audit Findings</u><br>Five audits were completed each month in September 2013, October 2013, and November 2013.<br><br>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 and compliance for specific questions and for Provisions V.1, V.2, and V.3. The Report also provided data on Interrater agreement on the Section V monitoring tool. From the Active Record and Individual Notebook audit tools, a graph was provided of errors by discipline each month and of errors by Records Clerks. A graph was provided of Individual Notebook Security based on audits by Records Clerks each month. Although some information, such as overall compliance on the monitoring tool, are presented each quarter, the QA department (including the URC) reported they determine the specific other data to be provided, based on what issues need to be brought to the attention of the Committee for review and possible action.<br><br>Provision V1 reports on data in the trend report on the presence of components of the Unified Record and on overall compliance for the Section V monitoring tool and for specific sections of that tool.<br><br>As noted in Provision V4, information on the use of records during annual ISP meetings was also provided in the latest quarterly report.<br><br><u>Corrective Actions</u><br>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. | |

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| | | As reported by the URC and verified by review of audits, the process of correction began following the audit with the URC sending an email of the findings and corrective actions needed to the people responsible for the specific documents or to administrative staff responsible for actions requiring training or systemic improvements (such as improving legibility, which cannot be corrected on the document itself but should be improved on current and future documentation). A due date for responses of five business days was stated in the emails.<br><br>For 15 of 15 audits reviewed (100%), documentation was provided that corrective actions were required for the deficiencies identified.<br><br>The Facility reported that the next step in the process was for the URC to track findings sent for correction between five and 10 days after sending the required actions. The Facility maintained and provided for Monitoring Team review a DSSLC Monthly Audit Tracking database report. This listed the home, date of audit, individual, discipline and person responsible, correction needed, category of correction (e.g., purge, missing current, legibility, missing date or time, gaps), evidence of correction needed, due date, date completed, and completion status. Records Clerks were to notify the URC when corrections were completed. The reports were organized by date of audit and were monthly; the Monitoring Team did not determine whether the Facility could draw a list of items for which corrections had not been made, so items from prior months would not be missed if not yet corrected. If this is not currently available, the Monitoring Team would suggest it be made available for routine checking. The information can be drawn by individual. The Monitoring Team did review the report for Individual #457; the items on the database were identical to those sent out for correction.<br><br>The Monitoring Team selected randomly by computer from audits done in August the record for Individual #457 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. Some issues that could not be corrected but were retrained were improved but not completely corrected; for example, one printed name was not legible (but the database listed this as not cleared). Two cleared items had not been fully corrected; a Record Order was not current in the Individual Notebook, and a Trigger Data Sheet and Flow Sheet were removed from the Individual Notebook as required but had not been filed in the Active Record. The URC stated she would retrain the Record Clerk and make expectations clear.<br><br><u>Review of Trends and Use of Audit Information for Systemic Improvement</u><br>As described earlier, the QA/QI Council reviewed trend data. The URC reported that a work group on legibility and one on misfilings at one unit were being started; | |

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| | | interestingly, the last compliance report stated that a systematic improvement plan had been implemented on legibility of signatures but had not been effective. It was not clear whether the new work group on legibility was an outgrowth of the prior improvement plan or was a new initiative.<br><br><u>Conclusion</u><br>This provision continues to be in substantial compliance with requirements. The audit system is robust and comprehensive. At least five random audits are conducted each month, and these are supplemented with additional audits of specific items in the record. Reliability across auditors is adequate. Audit findings for individual records are sent to staff responsible for making corrections. The Facility has a system for tracking corrections; although nearly all cleared items had been corrected, the Facility needs to be cautious and ensure all cleared items have been corrected. In addition, the Facility should consider ways to check on those items for which the specific deficiencies cannot be corrected but for which training or reminders are provided, such as legibility, to determine whether they improve. The Facility has addressed some systemic issues with varying degrees of success. | |
| V4 | Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions. | The Monitors and the parties agreed to a list of actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at DSSLC.<br><br><u>Records are Accessible to Staff, Clinicians, and Others</u><br>As reported in Provision V1, the Active Records and Individual Notebooks were usually accessible. Audits of 15 records conducted by the Facility in September, October, and November 2013 found 15 (100%) records were accessible. For three of three individuals checked by the Monitoring Team in visits to apartments (100%), the Individual Notebook was readily accessible. For four of five individuals checked (80%), the Active Record was readily accessible. For Individual #413, only one of three charts in the Active Record was present, and locating the others required as search because the checkout book was not present.<br><br>The Individual Notebooks do not contain the Integrated Direct Support Professional Care Plans for healthcare. The Facility decided to place them in the Red Care Plan Books in the homes. The books were subdivided by individual and contained four sections per individual: The Integrated Direct Support Professional Care Plans, Acute Care Plans, the medication sheet instructions, and the IHCP. This allowed the Direct Care Professionals (DSPs), floor nurses, and RN Case Managers to have ready access to these documents.<br><br><u>Documents are Filed in the Record Timely and Accurately</u> | Noncompliance |

| # | Provision | Assessment of Status | Compliance |
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| | | The Section V monitoring tool checked whether documents in the record were current. For the 15 audits conducted by the Facility in September, October, and November 2013, responses to that item on the reviewed audits showed zero of 15 records (0%) was rated as Current. Audits of two records by the Monitoring Team rated one of two (50%) Current.<br><br>Other than the record audits, the focus of assessment of timeliness was on the presence of assessments 10 days prior to the annual ISP planning meeting. The Self-Assessments for Sections F and H included tables of timeliness of completion of assessments by discipline. For the period of August 2013 through November 2013, the table for Section F reported a monthly range of 84% to 90% of assessments were timely; other tables showed variation in timeliness across disciplines.<br><br>The Monitoring Team also viewed the assessments available on the shared drive for Individual #299, who had an annual ISP meeting scheduled within the next ten working days. For 19 assessments that were required per the ISP Preparation meeting, 12 (63%) were available. This was not consistent with the compliance rate reported in the tables for Sections F and H.<br><br><u>Data are documented/recorded timely on data and tracking sheets</u><br>In general, data were documented timely. Two areas needed improvement. As reported in Provisions S1 and S3, data on skill acquisition plans were not always recorded. Of the 20 data forms reviewed, 14 (70%) reflected incorrectly recorded data or had missing data. As reported in Provision K4, data were not always recorded. For example:<br>• For Individual #734, progress notes reflected no replacement behavior training for at least three months, as well as missing target behavior data for the majority of days each month. Data collection problems continued for multiple months. In addition, missing treatment data were graphed as zero displays rather than as missing data, potentially adversely affecting treatment decisions.<br><br><u>Staff surveyed/interviewed indicate how the unified record is used</u><br>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 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 Self-assessment reported that 18 of 18 interviews indicated staff made use of the records | |

| # | Provision | Assessment of Status | Compliance |
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| | | to make decisions on care, treatment, and training.<br><br>Interviews conducted at prior compliance visits consistently found that staff could report that records were used and could give examples of how they were used. During this visit, the Monitoring Team discussed use of records with two QIDPs but did not interview. Both QIDPs indicated the records used (and observation of meetings conducted by one QIDP verified use of records); they reported they can nearly always find what is needed, but there is sometimes delay in filing, and legibility remains a problem. They reported there is a pilot implementation of a spreadsheet and graph to track and report clinical indicators; this had been implemented at the beginning of the month. Further description of this QIDP Clinical Indicators review format is found in Provision H5. The Monitoring Team looks forward to reviewing that at the next visit.<br><br><u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u><br>The Facility used an extensive ISP monitoring checklist to assess a wide range of issues, one of which was use of the record at meetings. Per interview, five such monitorings were done each month. According to the self-assessment, data and information in the record were available and utilized in making decisions during 61.8% of meeting discussions (an increase compared to 39.37% reported for the last compliance visit period). These data, per interview and review of the quarterly QA/QI report of November 2013 for Section V which reported monthly percentage by question, was based on two questions on the on the ISP Monitoring Tool. One asked whether the IDT used the record effectively to identify progress or decline; the other asked whether team members reviewed each other's assessments prior to the meeting, based on discrepancies in the discussion. Although a third question had been added about whether the records were brought to the meeting, that information as not provided in the quarterly report, and the Monitoring Team did not determine whether it was included in the graphed data.<br><br>The Monitoring Team observed the ISP annual planning meeting for Individuals #567 and #791. Active Records were present at both meetings. Use of the records was variable.<br>• For Individual #567:<br>o The Individual had a pending CT scan. Staff at the meeting did not know when the individual last had a CT scan and did not look in the record to check.<br>o Sometime in the last year, the individual had a UTI; the RN Case Manager did not know when that had been.<br>• For Individual #791: | |

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| | | o The QIDP was observed looking through the records for information during the discussion of the Integrated Risk Rating Form (IRRF).<br>o The IRRF draft included data in some areas, such as weight, cardiac, fall, and diabetes.<br>o Several reports and comments about status were general statements such as, "This has improved" and "It's way down" but did not include data from the records. Some, such as the discussion of behavioral risk, included data (on psychiatric symptoms).<br><br>The Monitoring Team observed the ISP Prep meeting for Individual #487. The record was present. The QIDP reviewed and discussed the meal documentation from the Active Record; the information was consistent with what the direct support professional at the meeting had reported. Data were presented on the individual's weight over the course of months; this led to a concern that some weights might have been determined without considering the weight of the wheelchair, an issue that will require further review. The QIDP also presented data on a skill acquisition program, on bowel movements and constipation, on falls, and on the last MOSES side effects scale score, and checked the date of the last DEXA. The dietitian provided information on calorie intake. The nurse estimated the number of sinusitis events but did not look it up to ensure accuracy, nor did she have information on whether a diagnostic study had been scheduled; the QIDP asked her to look up that information and provide it later. Overall, there was good use of the record, especially by the QIDP.<br><br>The Monitoring Team observed a Change of Status meeting for Individual #567. Records were present, and information from the record was used (some by looking up in the record, and some by use of record information that was brought in by participants). Data on clinical indicators were presented, including lab levels at specific dates.<br><br><u>Additional Information from the Monitoring Tool</u><br>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. Of 15 audits provided by the Facility for the months of September, October, and November 2013,14 audits (93%) reported entries by more than five disciplines; however, it should be noted that the auditors counted varying nurses as multiple disciplines (e.g., RN, RNCM, LVN, PNMT RN), counted Medical, Physician, and Nurse Practitioner as separated disciplines, | |

| # | Provision | Assessment of Status | Compliance |
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| | | and counted "Clinic" as a discipline. Nonetheless, all included at least medical and nursing disciplines, and most included other clinical disciplines such as speech/language pathologist, Dental, and psychologist.<br><br><u>Conclusion</u><br>This provision is not yet in substantial compliance. Although most information is accessible, inconsistent use of the Checkout process made it difficult to find a record. Timeliness of assessments so they are useable in preparing for ISP planning needs further improvement. The Facility's data indicated a need to improve use of the records at meetings for decision making; observation by the Monitoring Team showed improvement but still some inconsistency. | |

# List of Acronyms

**Denton State Supported Living Center**
**January 13-17, 2014 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 |
| BHS | Behavioral Health Specialist |
| BIR | Behavioral Incident Report |
| BMC | Behavior Management Committee |
| BMD | Bone Mineral Density |
| BP | Blood Pressure |
| BSC | Behavior Support Committee |
| 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 |

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| 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 |
| CoS | Change of Status |
| 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 |
| DRA | Deficiencies Requiring Action |
| 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 |

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| 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 |
| HPI | History of Present Illness |
| HRC | Human Rights Committee |
| HRO | Human Rights Officer |
| HSCC | Health Services Compliance Coordinator/Officer at Denton SSLC |
| HST | Health Support Team |
| HT | Habilitation Therapy |
| IBHA | Integrated Behavioral Health Assessment |
| 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 |
| LTAC | Long Term Acute Care Facility |
| 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 |

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| 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 |
| PCA | Program Compliance Auditor |
| 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 |

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| PMAB | Physical Management of Aggressive Behavior |
| PMOC | Psychiatric Medication Oversight Committee |
| PMR | Psychiatric Medication Review |
| PMR-SIB | Protective Mechanical Restraint for Self-Injurious Behavior |
| 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) |
| PRP | Polypharmacy Review Panel |
| 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 |

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| 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 |