United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center
July 21-25, 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, Lori Powell, 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.

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. The Facility provided several examples in which it had considered recommendations and ideas presented by the Monitoring Team both in the last compliance report and in discussions during the last visit, and had developed or revised practices.

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 458 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. For some Sections of the Settlement Agreement, the Facility had begun to rely more substantially on data collected through the Facility's Quality Assurance/Improvement (QA/QI) processes. The Facility should continue to expand on use of information from its QA/QI reviews so that its assessment of status is part of routine practice.

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 and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. For a few Sections, the Facility provided a list of ongoing activities; this provides information on on-going activities that the Facility must maintain, which is important in ensuring the Facility continues to implement those important activities. It also separates those from new actions that remain needed. This change in format is useful, and the Monitoring Team suggests the Facility expand on this to other Sections.

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

Use of restraint continued to be infrequent. The Facility had done an exemplary job of ensuring restraint is used only as a last resort when no other mechanism exists that can remove an Individual from a situation that represents immediate and serious risk to the Individual or others. Issues with documentation and with monitoring following restraint remain.

- Positive Practices and Improvements Made
    - The Facility has been diligent in ensuring all less restrictive measures to avoid use of restraint (including just letting a behavioral outburst "run its course") are attempted prior to a decision to restrain.
    - The Facility did not report any instances of use of Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB).
    - The Facility used video surveillance tapes extensively in its review of restraint episodes. Additionally, the Video Camera Operators were trained in detecting interactions between staff and Individuals that may be restraint. In these instances this was reported to the Behavioral Services Department who would review the tape and follow-up accordingly.
    - The Facility's restraint review practices were improved and, compared to the prior reviews by the Monitoring Team, were more effective in identifying factors that needed to be addressed to minimize future use of restraint with the particular individual being reviewed.

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 the Facility had made significant progress 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 in an early implementation stage.

Abuse, Neglect and Incident Management

The Facility increased the number of provisions in substantial compliance, with two provisions continuing to need improvement to achieve compliance. 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 number of confirmed findings of abuse and neglect had decreased from 15 to nine, comparing the two most recent six-month periods.
    - The Facility continued two excellent practices noted by the Monitoring Team in its last report: 1) taking additional steps to protect the integrity of testimonial evidence by implementing a "Testimonial Evidence Acknowledgment Form", and 2) putting screen saver slides reinforcing abuse and neglect reporting on computers used by Direct Care Professionals (DCPs).
    - The audit procedure required by DADS to detect under-reporting of significant incidents had been in place at the Facility and was being administered correctly.
    - Improvement in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs) was evident. The Monthly Trend Meeting (a component of the QA program) was an important element of this process.
- Improvements Needed
    - Late reporting of allegations of abuse, neglect, and serious incidents still occurs too often.
    - The Facility needs to monitor and ensure that recommendations from investigation reports, when accepted, are carried out to conclusion. The Facility needs to determine 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.

<u>Quality Assurance</u>

The Facility had made substantial progress since the last review. The basic administrative framework for a dynamic QA program was in place but needs time to mature. All Provisions of the SA had inter-rater reliability associated with monitoring and auditing tools.

- Positive Practices and Improvements Made
    - The Facility's QA process 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.
    - The system for the development and tracking of Corrective Plans, including the evaluation of their effectiveness was noticeably improved from that observed at the last review by the Monitoring Team.

- 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 could be examined for most data points.
- Key indicators were better defined than observed at the last review. For the most part it was possible to measure improvement or regression in the metric described in the key indicator.
- 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 were exemplary. They were extensive and provided much useful data for review, analysis, discussion, and decision-making. Additionally, section leads also prepared narrative information for each report that included, 1) accomplishments for the last three months, 2) upcoming challenges and plans for overcoming these challenges, 3) data analysis, 4) review of corrective action plan(s), 5) status of policy/procedure review, revisions, and implementation, 6) summary of any relevant committee recommendations, and 7) priorities for the next quarter. The Monitoring Team found the organization of these reports to be very user friendly.
- Additionally, the Facility had implemented a Monthly Trends Meeting in which data associated with incidents, injuries, and restraints were reviewed; and a monthly Residential Services Management Team (RSMT) report which provided the RSMT (the Director of Residential Services and the Unit Directors) extensive detailed data related to topics unique to things happening, or not happening, on the residential units.
- 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.
- There was an adequate system for tracking the status of CAPs and a regular review of CAP status at the monthly QA/QI Council meetings. Since the last review the Facility had developed a system for evaluating the effectiveness of CAPs.

- Improvements Needed.
  - Although significant progress had occurred since the last review, full and complete implementation of data collection, review, and analysis had not as yet been achieved.
  - There remained a need to improve submission of QA Matrix plan data to the QA department as scheduled.
  - The Facility had developed and implemented a systematic method to assess the effectiveness of a CAP and modify a CAP accordingly. This system was still in the early stages of implementation at the time of this review and has the potential to lead to substantial compliance in the near future.

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

There were areas in which the Facility made significant progress, and other areas with little progress. The Facility had focused on training staff to carry out ISP processes. An ISP Compliance Workgroup had also been formed to begin working with individual IDTs starting with the ISP preparation meeting and following through until completion of the ISP meeting, including post ISP preparation of documents and monitoring of the plan for the first three months.

- Positive Practices and Improvements Made
    - The Facility had begun implementing a significant effort to improve on its processes to better support individual understanding of and participation in the ISP process resulting in continued improvement in actual meeting participation by individuals.
    - The Facility had expanded upon and formalized a previous Corrective Action Plan to encourage a fuller discussion of Community Living Options at annual ISP planning meetings.
    - The Facility was to be commended for its continued efforts toward developing a comprehensive quality assurance system for this Section, including, for example a recently implemented change to its tracking and notification procedures, including a weekly Pre-Delinquency and Delinquency List provided to all Departments for attention and follow-up, which appeared to show significant early improvements in timeliness of ISP completion.
- Improvements Needed
    - 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.
    - IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
    - ISP strategies did not reflect encouragement of community participation in a meaningful or purposeful manner.

<u>Integrated Clinical Services</u>

Considerable progress has been made in integrating clinical services, especially at a systemic level. Examples of lack of integration in clinical services to individuals continued to be found, but improvement was found overall. The commitment to integrated planning at a systemic level was made evident by the participation of the Facility Director in the Physical and Nutritional Management Committee (PNMC). The Facility is approaching substantial compliance with this Section.

- Positive Practices and Improvements Made
    - Improvement in the format and participation in the Integrated Morning Report shows promise of establishing integrated planning as routine, as well as providing an excellent venue for integrated discussion and identification of issues needing collaborative planning.
    - Numerous interdisciplinary committees and workgroups provided means to address both systemic and individual issues in an integrated manner.
    - Documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and observations of Integrated Morning Report meetings and review of minutes documented examples of follow up with IDTs. Although consultation documentation did not indicate referral to the IDT, the Facility had an

appropriate process in place to facilitate documentation of review of recommendations from non-facility clinicians through the IMR, and to make referrals to the IDT when appropriate. This provision is found to be in substantial compliance.

- Improvements Needed
    - There were examples of excellent integrated planning for individuals, but also other examples in which this needed improvement.

Minimum Common Elements of Clinical Care

The Facility continued to take action to improve timeliness and use of assessments and clinical indicators. Improvement continued in some areas, such as comprehensiveness of assessments and systemic review of clinical indicators. Other areas showed less improvement, such as use of information from assessments and from clinical indicators. The Facility established or enhanced processes, such as the Change of Status meetings and the RSMT report; these should facilitate progress toward compliance.

- Positive Practices and Improvements Made
    - Diagnoses were consistent with current classification systems and clinically fit assessments and evaluations.
    - Both timeliness and clinical appropriateness of treatments and interventions had improved, although there were enough exceptions to result in a finding of noncompliance.
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- Improvements Needed
    - Timeliness of assessments continued to be high overall and had improved but variable across departments, according to Facility data. Review by the Monitoring Team found a slight decline in timeliness since the last compliance review.
    - Use of assessment data to make decisions on treatments, supports, and services was variable.
    - Although 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. 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.
    - Improvement needs to be made in implementing monitoring as planned and in reviewing and evaluating the information each month.
    - 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.
    - Although policies have continued to be developed and to evolve, implementation still must improve in order to find substantial compliance.

At-Risk Individuals

The Monitoring Team observed steady progress in moving towards compliance with this Section, most notably in the content and attendance at the Integrated Morning Meetings and in the use of the IMRT in tracking change of status events. While some compliance scores improved from that noted in the last review others did not. Overall the Facility demonstrated improvement in its at-risk processes from that observed at the last review.

- Positive Practices and Improvements Made
    - The statewide risk assessment policy, with guidelines for rating risk, was in use. The Facility also used supplementary tools that IDTs could reference in the risk assessment planning process.
    - The Facility had initiated a specific policy (CM 14) addressing its At Risk system.
    - The Facility continued to have a very active Physical and Nutritional Management Committee. It was evident to the Monitoring Team that the work of this committee was substantive and oriented to decision-making. The committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this Provision.
    - Interdisciplinary clinical coordination continued to improve from that noted in previous reports.
- Improvements Needed
    - Most of the compliance scores reported in Provision I.2 and I.3 had not changed significantly from that reported in the last report by the Monitoring Team and remain at a level that is not sufficient to find substantial compliance.
        - Assessments were not consistently adequate to assist the IDT in developing an appropriate plan to address risk, except that the Facility took immediate action in all cases when risk warranted.
        - Plans were not consistently implemented timely, nor did they consistently meet the needs identified by the IDT.

Psychiatric Care and Services

At the time of the visit, nine of fifteen provisions were in substantial compliance. No new provisions came into compliance during the visit, but progress was noted in many, and several are close to reaching substantial compliance. The Facility had improved its methods for quality assurance of psychiatric practices. That supported an effective dialogue between the Monitoring Team and the Facility about where efforts for improvement should be focused.

- Positive Practices and Improvements Made
    - Improvements in internal quality assurance have helped raise the quality of psychiatric assessments, which were close to levels needed for substantial compliance.
    - Several provisions remained in substantial compliance.

- Improvements Needed
    - Additional work was needed to successfully complete the transition to the newer treatment plan and medication monitoring formats.
    - Although the Facility developed new strategies to reduce the need for restraint, this continued to need improvement.
    - Psychiatric Support Plan documentation of the non-pharmacological supports that were place, to minimize the need for psychotropic medication, continued to need improvement.
    - There remained a need to improve identification of which modalities of behavioral health treatment (behavioral, pharmacological or other, in combination or alone) are offered to individuals, and why.

Psychological services

It was apparent that that the Facility had built upon previous achievements and continued to make progress; at times, that progress was considerable. It also appeared that the Facility was working toward substantial compliance in a systematic and coherent manner. Although an extensive amount of work remained, it was suggested that current processes were effective. Although Section K was not found to be in substantial compliance, the Facility should be commended for the continued effort toward satisfying the requirements of the Settlement Agreement.

- Positive Practices and Improvements Made
    - The Facility had maintained 100% of staff either possessing or working toward behavior analyst board certification.
    - The Facility continued to employ an adequately credentialed director of psychological services.
    - The Facility continued to utilize a comprehensive internal and external peer review process.
    - The majority of IBHA/PBSPs were based upon comprehensive behavior assessments.
    - The Facility continued to maintain an exemplary process for development and implementing counseling services.
    - The majority of IBHA/PBSPs were comprehensive and met current standards of practice.
    - Other than reliability and treatment integrity data, behavior data graphs were clear, comprehensive, and reflected all essential components.
- Improvements Needed
    - Reviews reflected that only 60% of IBHA/PBSPs were completed by a BCBA
    - The monitoring of behavior intervention effects continued to reflect weaknesses, such as a lack of BCBA review of progress and inconsistent measurement of reliability and treatment integrity.
    - The Facility was unable to provide consistent and timely assessment of intellectual ability and adaptive skills.
    - Very few IBHA/PBSPs completed by DSSLC adequately differentiated between behavior and mental illness targets, and did not integrate behavior and psychiatric interventions.
    - Individuals recently admitted to the Facility often were not provided with assessments of intellectual ability and adaptive skills within 30 days of admission.

Medical Care

The Facility has made extraordinary efforts to move the Facility closer to compliance with Sections L.1 through L.4.

- Positive Practices and Improvements Made
    - The Facility developed and implemented many new policies, including a policy to ensure appropriate actions following the death of an individual, and a comprehensive quality assurance policy.
    - The integrated morning meeting process has been significantly enhanced, with increased discussion, planning, and follow up.
    - Initial triage of acute medical conditions is prompt and appropriate.
- Improvements Needed
    - The Facility must improve management of pneumonia and follow-up to chronic care conditions.
    - Development of medical action plans needs to be enhanced.
    - Although initial triage of acute medical conditions is appropriate, follow up to acute medical conditions through full resolution of the condition is inconsistent.
    - The Facility is currently developing and implementing a comprehensive medical quality assurance process. This will require enhancement of medical audit reviews, medical quality assurance process, and mortality review process.

Nursing Care

The positive nursing practices identified in previous reports for this Section continued to be maintained and strengthened. Significant improvement was found in meeting some, but not all, requirements of this Section.

- Positive Practices and Improvements Made
    - If the requirements for Hospital Liaison Nurses, Infection Control Program, and Emergency Response activities were standalone activities they would be considered in substantial compliance.
    - The Skin Integrity system showed significant improvement. Over the past six months the data showed a reduction in the incidences of pressure wounds.
    - The required Nursing Administrative, Management and Specialty Nursing staffs consistently attended the Integrated Morning Report. This meeting appeared to have enhanced communication and integration of services across all clinical disciplines.
    - There was significant improvement in the timeliness and quality of nursing assessments completed according to the Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. The required nursing assessment items contained on the 12 nursing assessment forms were completed thoroughly and reflected good quality.
    - The Nurse Educators continued to maintain a robust competency based educational program that tracked all required training to ensure the training was completed.

- The required nursing policies, procedures, processes, and protocols were implemented and being followed.
- The Facility continued to maintain a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.

- Improvements Needed
  - Although the Nursing Department continued to make efforts toward improving the individualization and quality of the Acute Care Plans, no appreciable improvement was found in the individualization and quality of the Acute Care Plans. Acute Care Plans were often not initiated for acute temporary changes in health conditions, for which plans should have been developed.
  - Integrated risk rating and health care plan processes continued to evolve but had not matured sufficiently to demonstrate substantial compliance.

<u>Pharmacy Services and Safe Medication Practices</u>
The Facility has made marked improvements in the area of pharmacy services. All provisions of this Section were found in substantial compliance.

- Positive Practices and Improvements Made
  - Significant improvements were noted with more relevant clinical information being provided on the Quarterly Drug Regimen Reviews (QDRRs), and more comprehensive review of polypharmacy, benzodiazepine usage, anticholinergic usage, and assessment of metabolic syndrome.
  - The pharmacist documented review of newly ordered medications for allergies, indication, dosage, route, and potential interactions.
  - The Facility had enhanced its reporting of adverse and potential adverse drug reactions on the IRRF assessments.
  - The Monitoring Team remains complimentary of the Facility's medication variance and drug utilization evaluation process. The Facility continued to implement and maintain a robust process to track, trend, analyze, and implement corrective action, when necessary, for medication variances. The Facility's database for tracking medication variances is robust, and not only delineates the severity of variances, but identifies the relevant department, and staff member who was responsible for the variance.
  - There was documented evidence demonstrating review of new medication orders by the pharmacists for adverse drug reaction, allergies, appropriate indication, and dosage.
- Improvements Needed
  - There were many examples cited of MOSES and DISCUS assessment forms not being fully completed by the medical provider.

<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 and lacked the thorough discussion needed to fully address signs, symptoms and associated risks. Additionally, there continued to be difficulty in transitioning and integrating information into the Integrated Health Care Plan. PNMPs were noted to remain comprehensive and provided staff with detailed strategies to mitigate associated PNM risks if followed.

- Positive Practices and Improvements Made
    - An adequate Physical and Nutritional Management Team (PNMT) was now back in place as evidenced by consistent participation by the PT and the RD.
    - The Physical and Nutritional Management Committee (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.
    - New Employee training was comprehensive and DSSLC provided annual or refresher trainings that focused on preventing aspiration and providing proper transfer and lifting.
    - PNMPs contained all the required components in the areas of dining, medication administration, bathing, personal care, and lifting/transfers.
    - PNMPs across the various locations (i.e., MARs and "Me" books) were consistent and appropriately updated.
- Improvements Needed
    - The risk process continued to improve in its ability to identify those individuals who are at increased risk but still was lacking in its comprehensiveness and accuracy.
    - 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. This was especially evident when the PNMT was not directly involved.
    - 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.
    - 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.
    - All areas in which difficulties are likely to be provoked were not receiving adequate monitoring. DSSLC was developing a new monitoring process in which the frequency of the monitoring would be determined on an

individual basis and included as part of the IHCP and OT/PT assessment. This process will need to be reviewed once implemented.
  - 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.
  - Although pathways to oral intake (PO) status and the implementation of oral motor strategies to improve oral control and maintenance had shown significant improvement but lacking was consistent evidence of IDT review and acceptance prior to the initiation of the oral motor treatment program.

<u>Physical and Occupational Therapy</u>
DSSLC continued to show improvement with services identified within this provision. The assessments continued to improve and provided a more comprehensive review of the individual. Indirect Supports (i.e., PNMPs) showed significant improvement and did a nice 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
  - All areas within the assessment including but not limited to comparative analysis, inclusion of information regarding risk levels and how they impact functional skills and health status were noted to have continued improvement with the exception of the identification of the monitoring schedule.
  -
- Improvements Needed
  - Identification of the monitoring schedule in assessments and containing recommendations for effectiveness and compliance monitoring needed improvement.
  - Monthly documentation from the OT and PT and/or QIDP 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 by staff. A formal monitoring system was not fully implemented that allowed for the adequate monitoring of OT/PT supports.
  - 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.

Dental Services

As noted during the last compliance visit, 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, and restorative treatments, are provided at the level of standard of care practice.

Positive Practices and Improvements Made

- The Facility ensures close monitoring of individuals when provided anesthesia services.
- Annual dental assessments are completed timely.
- The Facility has enhanced several policies to better delineate its process for suction toothbrushing and the provision of oral health care at the living area.
- Through the Facility's QA/QI process, the Facility had significantly improved its process for tracking and trending missed dental appointments.
- Restorative treatments are provided promptly.

- Improvements Needed
  - Documentation of dental emergencies was not effective, and there was delay in providing prompt treatment of dental care for dental emergencies.
  - The Facility must 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 associate with the provision of oral healthcare.
  - Although the Facility had an effective system for evaluating the quality of dental treatments, it 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 did not provide evidence of substantially implementing programs to help mitigate the need for restraint during dental treatments.

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. Presence in the ISP of how the individual communicates and how staff can bridge communication was much improved but integration into SAPs remained inconsistent.

- Positive Practices and Improvements Made

- DSSLC was at full capacity with regards to Speech Pathologists. 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.
- Individuals identified as having decreased communication were provided with comprehensive assessments or screenings that would identify the need for further assessment. 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.
- Integration into the ISP had shown improvement as evidenced primarily by improved comprehensiveness of the PNMP and statements regarding how staff can better bridge any gaps in communication.

- Improvements Needed
  - Concerns were noted regarding AAC being readily available and utilized within the home environment.
  - A monitoring process was not implemented that will ensure all devices are working properly, are available, and staff are provided consistent modeling on how to use the devices.
  - DSSLC did not have a comprehensive monitoring system that covered the presence and condition of Alternative and Augmentative communication devices, and implementation of the device. DSSLC had developed a system that had the needed guidelines but the process was still in the implementation stages and did not have sufficient and consistent data to determine compliance at this time.

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

It was apparent that the Facility had attempted to improve the quality of services addressed by Section S of the Settlement Agreement. In the majority of areas, however, no substantive progress was noted and at times, the Facility had regressed.

- Positive Practices and Improvements Made
  - Skill Acquisition Programs reflected somewhat greater individualization in the development process.
  - Skill acquisition programs were somewhat more likely to include appropriate discriminative stimuli, specific instructions, and specific consequences for correct responses.
  - Substantial improvement was noted in the inclusion of maintenance and generalization strategies in skill acquisition programs.
  - Skill acquisition programs were likely to include strategies that were practical to implement.
- Improvements Needed
  - Less than half of the skill acquisition programs were based upon adaptive skill assessments, fewer than a third reflected needs identified in the ISP, and none were based upon a task analysis. In several instances, various assessments for the same individual were contradictory.
  - Skill training continued to lack the frequency of training trials necessary to develop and strengthen new skills.

- The number of individuals provided functional engagement remained essentially unchanged while the percentage of locations with at least 50% functional engagement had dropped for the second consecutive site visit.
- Skill acquisition data were incomplete or included documentation errors for two-thirds of the individuals reviewed.
- The majority of skill acquisition programs were not implemented consistently or correctly.

Most Integrated Setting

The Facility maintained a stable and reasonable number of transitions to more integrated settings. There were numerous areas of progress toward compliance. Turnover of post-move monitoring staff may have affected progress in improving the monitoring following transitions.

- Positive Practices and Improvements Made
  - The Facility continued to develop and implement innovative approaches to addressing obstacles to transition.
  - DSSLC was to be commended for enhancing staffing resources to support referrals and transitions, particularly in the assignment of a Habilitation Therapies staff to assist with transition activities, including provider training, pre-move site reviews and post-move monitoring. This was a very valuable addition, particularly as individuals with significant physical and nutritional management needs transition to the community.
  - The Facility maintained substantial compliance with those provisions that 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.

- 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, but was making progress.
  - As indicated in Community Living Discharge Plans (CLDPs) that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living, improvement is needed in identifying in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation.
  - The Facility reported PMM Checklists were generally being completed in a timely manner and included visits to all sites at which the individual lived and worked/day activity, as required, but documentation processes made it difficult to fully evaluate this assertion.
  - The PMM Checklists reviewed in depth and the observation of a PMM visit indicated that post move monitoring was not yet conducted in a sufficiently thorough manner. 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 remained a significant barrier to an accurate and comprehensive post-move monitoring process.

Consent
The parties agreed the Monitoring Team would not monitor this Section, due to limited progress.

Recordkeeping and General Plan Implementation
The Facility maintained a unified record for each individual. Compliance with Appendix D requirements had shown slight declines since the last report period, but the Facility has taken steps to address that by providing data to residential managers so that they can act to improve compliance.

- Positive Practices and Improvements Made
  - The Unified Record contained all required components.
  - Records were in generally good condition, were accessible and secure, included most documents, and were legible.
  - The Facility has policies to cover most provisions of the Settlement Agreement; adoption and localization of some State Office policies, and ensuring all requirements of provisions are addressed, should address nearly all provisions.
  - The audit system continued to be robust and comprehensive. At least five random audits were conducted each month.
  - The Facility has a system for tracking corrections identified in audits as needed that tracks deficiencies until there is evidence they have been corrected.
- Improvements Needed
  - The Facility showed slight declines in the level of compliance with Appendix D requirements compared to that found at the last compliance visit. This was in spite of having a robust audit system. The Facility had taken new steps to improve, primarily through providing data to the residential management staff along with expectations they will take responsibility for improvement.
  - Procedures for routine review and revision of policies are lacking.
  - Procedures for identifying who needs to be trained and the kind of training to be provided, and for ensuring training has occurred, need to be formalized. There is no efficient way to ensure timely that all staff needing training have been trained.
  - Although reliability across auditors was adequate, although there arose a concern about independence of the reviews.
  - The Facility's data and Monitoring Team observations of meetings showed improvement in presence and use of records but still some inconsistency, indicating a continuing need to improve use of the records at meetings for decision making.

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

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. DSSLC Presentation Book (undated) 4. DADS Policy 001.1: Use of Restraint 4/10/12 5. DADS Policy 001.2: Use of Restraint 4/4/14 6. DSSLC Policy CMGMT-20 Use of Restraint 2/1/13 7. DSSLC Policy CMGMT-20 Use of Restraint 6/1/14 8. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint 5/15/14 9. Sample of staff training records (Sample C.2). This consisted of 24 staff selected because they were involved in restraint application or unusual incidents 10. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 7/21/14 11. Restraint log for crisis intervention restraints 2/1/14 to 6/17/14 12. Restraint log for medical restraints 2/1/14 to 6/17/14 13. Restraint documentation files for Sample C.1 of 11 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 #251, #456 (2x), #21, #727 (2x), #626, #671. #127, and #110 (2x). This is a 100% sample. 14. Restraint documentation files for Sample C.3 of medical restraint for Individuals #445 (5/5), #556 (2/6), #75 (4/30), #295 (4/30), #37 (3/12), #459 (4/16), #656 (5/14), #654 (4/29), #461 (4/10), #33 (4/2), #793 (5/5), #169 (3/19), #332 (3/18), #209 (4/7), #429 (2/24), #413 (4/10), #661 (4/30), #772 (3/19), #572 (5/28), #487 (5/12), #672 (4/23), #314 (2/13), #1 (5/15), #749 (5/21), #379 (4/30), #370 (5/5), #87 (2/26), and #152 (4/3). This was a 15% sample. 15. Sample of records associated with Individuals using abdominal binders (Sample C.4) for Individuals #715, #102, #690, #394 and #167 16. Restraint Trend Analysis 6/14 **People Interviewed:** 1. Trenton Berrie, Acting Director of Behavioral Services, BCBA, Section C Lead 2. Jeremy Clay, Security Camera Monitor 3. Traven Brown, Security Camera Monitor 4. Tyrone Nash, Assistant Director of Competency Based Training 5. Serena Knox, Settlement Agreement Coordinator 6. Ten Direct Care Professionals (DCP's) **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 7/21/14 and 7/23/14

	2. ISPA for Individual #671, 7/21/14 3. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 7/22/14 4. Facility Monthly Trends Meeting 7/24/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section C, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data (if used), as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included those developed by DADS with the Facility to monitor Section C of the Settlement Agreement (SA). o For the most part, these monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools: Psychology Assistants and QA Program Auditors. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o The self-assessment did not indicate whether Inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. The QA Director reported inter-rater reliability had occurred. Nevertheless, data associated with this were not reported in the self-assessment document. ▪ Used other relevant data sources and/or key indicators/outcome measures, such as reviewing Facility policy to ensure alignment with SA requirements, reviewing training delinquency reports, reviewing employee/restraint monitor training transcripts, and conducting competency checks with employees. ▪ For the most part the Facility presented data in a meaningful/useful way. Notable exceptions were the absence of inter-rater reliability data and for Provision C.5 the absence of data to validate that i a physician specified the schedule and type of monitoring required in each instance of medical restraint. Generally, the Facility's Self-Assessment described what was being assessed, how the

	assessment occurred, and data associated with its findings. o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Provisions C.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 with four or more restraints in a 30 day period Provision C.7 was not rated; the Facility also did not have any individuals who met this criterion during the last compliance period and had been in compliance in the review before that. The lack of compliance with Provisions C.4, C.5, and C.6 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. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Actions were reported as either completed or in process. ▪ The Facility data identified areas of need/improvement. Generally, the discussion of the results of the self-assessment included narrative description of the operational issues which, based on monitoring data, needed improvement. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. For those Provisions determined by the Monitoring Team to be in noncompliance, the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: 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 to avoid use of restraint (including just letting a behavioral outburst "run its course") are attempted prior to a decision to restrain. 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 did not report any instances of use of Protective Mechanical Restraint for Self-Injurious

	Behavior (PMR-SIB). The Facility used video surveillance tapes extensively in its review of restraint episodes. Additionally, the Video Camera Operators were trained in detecting interactions between staff and Individuals that may be restraint. In these instances this was reported to the Behavioral Services Department who would review the tape and follow-up accordingly. 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. Review of Positive Behavior Support Plans confirmed that restraint was only being used for crisis intervention. As in past reviews, inconsistent restraint monitoring by nursing staff was noted and needs to be aggressively addressed. The Facility had made significant progress in complying with Settlement Agreement requirements associated with medical restraint. Still in an early implementation stage was the consistent development of strategies and programs to minimize the need for medical restraint. The Facility's restraint review practices were improved and, compared to the prior reviews by the Monitoring Team, were more effective in identifying factors that needed to be addressed to minimize future use of restraint with the particular individual being reviewed. Facility policy prohibits prone restraint and this prohibition is reinforced through staff training. The Monitoring Team review of restraint records, staff interviews, and minutes of the Incident Management Review Team (IMRT), did not discover any use of prone restraint.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to	The Facility reported the following with respect to restraint use: Type of Restraint / 7/1/13 to 12/31/13 / 1/1/14 to 6/30/14 Personal restraints (physical holds) during a behavioral crisis: 8 / 8 Chemical restraints during a behavioral crisis: 1 / 1	Substantial Compliance

#	Provision	Assessment of Status	Compliance

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.

Mechanical restraints during a behavioral crisis	1	1
TOTAL restraints used in behavioral crisis	10	10
TOTAL individuals restrained in behavioral crisis	7	8
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	2	2
Medical/dental restraints	380	440
TOTAL individuals restrained for medical/dental reasons	212	231

In its last two reports the Monitoring Team noted that the frequency of use of crisis intervention restraint had steadily decreased. During this review period the use of crisis intervention restraints had increased but still remained at a low level considering the Facility had over 250 Individuals with Positive Behavior Support Plans (PBSPs). Most of the increase in use of restraint was attributable to new admissions. 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 continued low utilization of crisis intervention restraint suggests the Facility continues to be very proactive in providing effective supports.

Sample C.1 consisted of crisis intervention restraints between 2/1/14 and 6/17/14 when the Facility prepared its response to the Monitoring Team's document request. This consisted of 11 restraints involving eight Individuals. One restraint was selected for each of the eight Individuals for Sample C.1. Therefore this was a 73% sample. In reviewing Sample C.1 the Monitoring Team did not find any instance of use of restraint for the convenience of staff or in a clinically unjustifiable manner.

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. As noted in the last report by the Monitoring Team, 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.

The continued infrequent use of crisis intervention restraint, along with data presented in this report, led the Monitoring Team to conclude that restraint was used in a clinically justifiable manner and not for the convenience of staff. Additionally, the Monitoring

#	Provision	Assessment of Status	Compliance
		Tools used by the DSSLC to measure compliance with this part of the Settlement Agreement (SA) for the eight episodes of crisis intervention restraint showed compliance with this specific requirement. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified. A sample, referred to as Sample C.1, was selected. (This was a 73% sample of the 11 crisis intervention restraints since the last review). Based on a review of the restraint records for individuals in Sample C.1 involving eight individuals, none (0%) showed use of prone restraint. Based on questions with 10 direct support professionals, all (100%) were aware of the prohibition on prone restraint. Most of these 10 staff were from residential areas where many Individuals had Positive Behavior Support Plans (PBSPs) and where restraint had occurred. <u>Other Restraint Requirements</u> Based on document review, the Facility and State policies do state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: In eight of eight records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. For the eight restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that eight (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. In eight 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.	

#	Provision	Assessment of Status	Compliance
		Facility policies do identify a list of approved restraints. Based on the review of eight restraints involving eight individuals all were approved restraints. In all eight records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. 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. The Facility reported it did not use Physical Mechanical Restraint for Self-Injurious Behavior (PMR-SIB). The Facility had 22 Individuals using abdominal binders associated with support for G/J tubes. Records for five of these 22 (23% - Sample C.4) Individuals were reviewed by the Monitoring Team. In each case they included documentation that the use of the abdominal binder was not related to the Individual's behavior and therefore did not represent restraint. For three of the five Individuals the Monitoring Team interviewed direct care staff who regularly worked with the Individual. For two of three Individuals (67%) staff reported the Individual does not pull at the G/J tube "mickey" or otherwise engage in behavior that might prove to be unsafe. Both described the abdominal binder as necessary because of involuntary movements or intentional movements such as rolling on their side. Staff for the third individual reported the Individual likes "to play with it' and he has free will to remove the binder and in fact occasionally does so. The Monitoring Team concluded the use of abdominal binders in these sampled instances did not represent Protective Mechanical Restraint for Self-injurious behavior. The Monitoring Team did not identify any use of abdominal binders that would be considered a restraint. The Monitoring Team interviewed two Security Camera Monitors to confirm their training in PMAB techniques and restraint use and their acknowledgement that identifying and reporting questionable interactions between staff and Individuals as possible restraint was within their scope of responsibilities. Both were very knowledgeable of appropriate and inappropriate interactions between staff and Individuals and knew to report any interaction that might be perceived as restraint to Behavioral Services for review. Both cited examples where they in fact did make such a report. Based on this review this Provision was in substantial compliance.	
C2	Effective immediately, restraints	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a	Substantial

#	Provision	Assessment of Status	Compliance
	shall be terminated as soon as the individual is no longer a danger to him/herself or others.	smaller sample) for this subsection, because previous reviews showed substantial compliance. The Monitoring Team selected four of the eight restraints in Sample C.1 for this review starting with the first restraint listed and selecting every other restraint. This included restraint of Individuals #251, #21, #626, and #127. Two of the four (50%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Those that did not included Individual #251 (no release code was noted on the restraint checklist) and Individual #21 (the release code noted on the restraint checklist was Y- "release completed"). Because the Facility had been in compliance with this Provision the Monitoring Team reviewed the other four restraints. For one (Individual #456) the release code noted on the restraint checklist was also Y- "release completed" although the entry was crossed out resulting in no code entered for release on the restraint checklist. In summary for the eight restraints in Sample C.1, sufficient documentation to demonstrate compliance with this Provision was present for five (63%). Based on this review the Monitoring Team determined this Provision remained in compliance in that temporary failure to comply during a period of otherwise sustained compliance, does not constitute failure to maintain substantial compliance. To remain in compliance the Facility will need to demonstrate at the next review that restraints were terminated as soon as the individual was no longer a danger to him/herself or others and will need to meet the Monitoring Team's metric benchmark of 90%.	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample C.2 was selected from a current list of staff. A description of Sample C.2 is provided in the Documents Reviewed section above. For Sample C.2 a review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 23 of the 24 (96%) had completed training in RES0105 Restraint Prevention and Rules within the last 12 months.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	• 22 of the 24 (92%) had completed PMAB training within the past 12 months. The Monitoring Team also reviewed a State report "Percent of All Employees Completing Courses of Training Program." This report indicated the following completion rates for DSSLC employees: 1. 98% RES0105 Restraint: Prevention and Rules for Use at MR Facilities 2. 95% RES0110 Applying Restraint Devices 3. 96% PMA0320 – PMAB Basic 4. 96% PMA0400- PMAB Restraint 5. 96% PMA0700 –PMAB Prevention 6. 97% PBS0100 – Positive Behavior Support These compliance percentages were sufficient to demonstrate substantial compliance with the training component of this provision. In order to evaluate staff knowledge in the area of restraint, 10 Direct Care Professionals were asked a series of questions. The 10 staff were selected by the Facility from a list provided by the Monitoring Team 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 Acting Director of Behavioral Services, and the Facility's Settlement Agreement Coordinator. Consequently, for each question, responses were subjected to 30 evaluations (ten individuals' times three raters). Based on responses to questions, ten direct support professionals provided satisfactory responses to the following questions as follows: • "Policies governing the use of restraint require that restraint should only be used if the Individual poses an _____and only after_____." Twenty-five of 30 responses were evaluated as satisfactory (83%). This compares to the 83% reported in the last review. • "Describe an example of a verbal redirection technique." Thirty of 30 responses were evaluated as satisfactory (100%). This compares to the 100% reported in the last review. • "Name two physical restraint techniques approved for use at the Facility." Fifteen of 30 responses were evaluated as satisfactory (50%). This compares to the 88% reported in the last review. Most incorrect responses, however, were technical, such as stating "personal" instead of "physical" hold. In some cases, staff provided only one approved technique. In no case did a staff answer with a technique that was actually not approved. • "What level of supervision is usually required when an Individual is in restraint?" Thirty of 30 responses were evaluated as satisfactory (100%). This compares to the 100% reported in the last review.	

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		• "Under what circumstances is it OK to use prone restraint?" All 30 responses were evaluated as satisfactory (100%). This compares to the 100% reported in the last review. • Overall 130 of a possible 150 ratings (5 questions times 30 possible ratings for each question) were rated as acceptable for an overall rating of 87%. This compares to the 94% reported in the last review. Based on the above data the Facility needs to strengthen its staff training efforts with regard to restraint use. In particular, the Facility should ensure staff are familiar with accepted techniques and the correct terminology. In eight 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. 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 eight restraint records (Sample C.1), in eight (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of the eight Positive Behavior Support Plans for Sample C.1, in eight (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. The Facility did not maintain a "Do Not Restrain" list. The Facility described its administrative/clinical process that was in place to demonstrate compliance with the SA requirement that "no restraint shall be used that is prohibited by the individuals medical orders or ISP". This process was documented using a form titled "Considerations for Implementing Restraint". This form was present, and properly completed, for all eight Individuals in Sample C.1. In reviewing Sample C.3 for 27 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Twenty-five (92%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • None (0%) included appropriately developed treatments or strategies to	Noncompliance

#	Provision	Assessment of Status	Compliance
		minimize or eliminate the need for restraint. Although such treatments or strategies were not included, IDTs provided an adequate justification for not developing a fading plan for none (0%) of the individuals in the sample.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. This training was competency-based. Based on review of restraint and training records, of the staff at the Facility who performed the duties of a restraint monitor for the restraints in Sample C.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: 1. ABU0100 Abuse and Neglect 2. PMA0320 PMAB Basic 3. PMA0400 PMAB4: Restraint 4. PMA0700 PMAB7: Prevention 5. CPR0100 CPR Basic 6. RES0105 Restraint: Prevention and Rules for Use at MR Facilities 7. RES0110 Applying Restraint Devices 8. PBS0100 Positive Behavior Support Based on a review of eight restraint records (Sample C.1), a face-to-face assessment was conducted: 1) in eight (100%) by an adequately trained staff member, 2) in eight (100%), the documentation showed that an assessment was completed of the application of the restraint, and, 3) in eight (100%), the documentation showed that an assessment was completed of the consequences of the restraint. In seven of eight (88%) restraints the restraint monitor was at the site of the restraint within 15 minutes. This was not the case for restraint of Individual #251. There were no instances of crisis intervention restraint where a physician had ordered an alternative monitoring schedule. Based on a review of eight crisis intervention restraint records, of which seven were physical restraints and one for chemical restraint, that occurred at the Facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in six of eight (75%) of the instances of restraint. Records that did not contain documentation of this included: o Individual #251: On 4/4/14 at 5:11 p.m.., physical restraint was	Noncompliance

#	Provision	Assessment of Status	Compliance
		applied. Monitoring was not initiated until 1750 (5:50 p.m.). o Individual #727: On 5/13/14 at 9:52 a.m., physical restraint was applied. Monitoring was not initiated until 1050 (10:50 a.m.). • Monitored and documented vital signs every fifteen minutes in three of eight (38%) instances of restraint application. Records that did not contain documentation of this included: o Individual #21: On 4/26/14 at 12:30 p.m., physical restraint was applied. Monitoring was not initiated until 1300 (1:00 p.m.). o Monitoring was initiated at the time the chemical restraint was administered but was not conducted every 15 minutes as required. o Individual #251: On 4/4/14 at 5:11 p.m.., physical restraint was applied. Monitoring was not initiated until 1750 (5:50 p.m.). o Individual #727: On 5/13/14 at 9:52 a.m., physical restraint was applied. Monitoring was not initiated until 1015 (10:50 a.m.). o Individual #110: On 4/24/14 at 1:13 p.m., physical restraint was applied. Monitoring was not initiated until 1330 (1:30 p.m.). o Individual #671: On 2/23/14 at 1855 (6:55 p.m.), a chemical restraint was administered. Monitoring was initiated at the time the chemical restraint was administered but was not conducted every 15 minutes as required. At the time the chemical restraint was administered the nurse documented that Individual #671 refused to allow temperature, pulse, and blood pressure taken but the respiration rate was recorded. There was no further monitoring documented after 1855 (6:55 p.m.) as required by policy for chemical restraint administration for at least two hours or longer if necessary. • Monitored and documented mental status every fifteen minutes in three of eight (38%) instances of restraint (although for these three, documentation of mental status should have included objective signs). Documentation of this included: o Individual #671: On 2/23/14 at 1855 (6:55 p.m.), a chemical restraint was administered. Monitoring was initiated at the time the chemical restraint was administered but was not conducted every 15 minutes as required. There was no further monitoring documented after 1855 (6:55 p.m.) as required by policy for chemical restraint administration for at least two hours or longer if necessary. o Individual #21: On 4/26/14 at 12:30 p.m., physical restraint was applied. Monitoring was not initiated until 1300 (1:00 p.m.). o Monitoring was initiated at the time the chemical restraint was administered but was not conducted every 15 minutes as required. o Individual #251: On 4/4/14 at 5:11 p.m.., physical restraint was applied. Monitoring was not initiated until 1750 (5:50 p.m.). o Individual #727: On 5/13/14 at 9:52 a.m., physical restraint was	

#	Provision	Assessment of Status	Compliance
		applied. Monitoring was not initiated until 1015 (10:50 a.m.). o Individual #110: On 4/24/14 at 1:13 p.m., physical restraint was applied. Monitoring was not initiated until 1330 (1:30 p.m.). • There was one non-serious injury documented related to the use of the restraints in the eight crisis restraint records reviewed. As suggested in previous compliance reviews, 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. Cardiac status should also be obtained through visual observation for evidence of cardiac 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. The Nursing Department should consider retraining the responsible nursing staff on DADS Policy 001.2: Use of Restraint 4/4/14 and DSSLC Policy CMGMT-20 Use of Restraint 6/1/14, regarding nursing's responsibilities for monitoring physical and chemical restraints. Sample C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 15% of the individuals for whom medical restraint was used. (Sample C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In 18 out of 27 (67%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • In 11 out of 27 (41%), the physician specified the type of monitoring required if it was different than the facility policy. • In 18 out of 27 of the medical restraints (67%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. • 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;	A sample (Sample C.1) of eight 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:	Noncompliance

#	Provision	Assessment of Status	Compliance
	and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• In eight (100%), continuous one-to-one supervision was provided. • In eight (100%), the date and time restraint was begun. • In eight (100%), the location of the restraint. • In eight (100%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. • In eight (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Provision C.8. Refer to above paragraph. • In eight (100%), the specific reasons for the use of the restraint. • In eight (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint. • In eight (100%), the names of staff involved in the restraint episode. • In five (63%) 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 Individuals #251, #456, and #21 (refer to Provision C.2). • All eight restraints were of short duration, the longest being five minutes. • In eight (100%), the level of supervision provided during the restraint episode. • In eight (100%), the date and time the individual was released from restraint. • In eight (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. In summary, 11 of 12 compliance scores were 100% and the overall compliance average was 97%. In a sample of eight records (Sample C.1), restraint debriefing forms had been completed for eight (100%) and data was generally consistent with data recorded on the Restraint Checklist. A sample of 27 Individuals subject to medical restraint was reviewed (Sample C.3), and in 18 (67%), there was evidence that the monitoring had been completed as required by the physician's order. 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:		

#	Provision	Assessment of Status	Compliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	During this review period no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated.	Not rated
	(b) review possibly contributing environmental conditions;	During this review period 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;	During this review period 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;	During this review period 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;	During this review period 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	During this review period no individual was placed in restraint more than three times in any rolling 30-day period. Therefore this provision was not rated.	Not Rated

#	Provision	Assessment of Status	Compliance
	settings and fully as written upon each occurrence of a targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	During this review period 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 initially 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 which by policy must occur no later than three business days after the restraint. . Additionally, the IDT would be expected to meet shortly after the restraint episode (within one business day) 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. In its last report the Monitoring Team noted that documentation to validate these steps was not always apparent in that 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". Much improvement was noted during this review. The Facility had initiated a "restraint discussion addendum" to be used as a discussion and documentation template by the IMRT when reviewing a crisis intervention restraint. The addendum records key data related to the restraint and probes the following: 1. Factors contributing to the restraint 2. Behavior that necessitated the use of restraint including a discussion of the imminent danger that made restraint necessary. 3. Team determination, conclusion, and recommendation including concerns and problems that need to be addressed immediately. In its last report the Monitoring Team noted 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. This was not the case during this review. The restraint review process demonstrated consistently reliable results. Documentation related to Facility review of eight incidents of crisis intervention restraint was reviewed by the Monitoring Team. This included the Unit Review Team meeting	Noncompliance

#	Provision	Assessment of Status	Compliance
		minutes, IMRT meeting minutes, ISP addenda, and debriefing documentation. This documentation showed that: • In five (63%), the review by the Unit IDT occurred within one business day 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 Individuals #21, #626, and #110. • In four (50%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented by date entry on the Restraint Checklist and review of IMRT minutes. This was not the case with restraint of Individuals #251, #21, #626, and #127. • In eight (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • In six (75%), 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 not the case with restraint of Individuals #21 and #626. In both cases the unit review was inadequate although the IMRT was adequate. This was a significant improvement from the 0% reported by the Monitoring Team in its last review. • In eight (100%), referrals were made to the team and the team met and made program changes as appropriate. Restraint data was reviewed monthly at a Facility Monthly Trends Meeting. Restraint practices, including those effecting specific Individuals, are part of the review and discussion at these meetings. Membership of this group included Residential Unit Directors, Behavioral Services staff, and other key administrative and clinical leadership at the Facility. The Quality Assurance/Quality Improvement Council (QA/QI) also reviewed restraint procedures used across the Facility quarterly. This would not typically include any discussion of an individual episode of restraint but did ensure a broader base of general review of restraint data and restraint practices at the DSSLC. Based on this review the Facility was not in compliance with this provision.	

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. Settlement Agreement (SA) Section D Presentation Book (undated) 4. DADS Policy 021.3 Protection From Harm – Abuse, Neglect, and Exploitation 11/5/13 5. DADS Policy 02.5 Incident Management 11/5/13 6. DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect, and Exploitation 1/15/14 7. DSSLC Policy CMGMT-01B Protection from Harm – Incident Management 11/13/13 8. Sample of Employee Training Records – Sample C.2 9. DADS Report MHMR0102 Percent of All Employees Completing Courses of Training Program 7/21/14 10. Allegation, Injury, and UIR Trend Report June, 2014 11. DFPS case log 2/1/14 to 6/18/14 12. OIG case log 2/1/14 to 6/18/14 13. Serious Incident log 2/1/14 to 6/18/14 14. Witnessed Injury log 2/1/14 to 6/18/14 15. List of the most frequently injured Individuals 2/1/14 to 6/4/14 16. List of Individuals causing the most injuries to other Individuals 2/1/14 to 6/16/14 17. Discovered Injury log 2/1/14 to 7/21/14 18. Peer caused injury log 2/1/14 to 7/21/14 19. Sample D.1: included a sample of DFPS investigation reports of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports for DFPS cases 43102154, 43128667, 43091794, 43166203, 43159441, 43113370, 43075722, 43038754, 43062407, 43144839, 43171854, 42124284, 43056736, and 43109627. 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. 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 130, 134, 142, 211, and 167. The sample was 20% of reported investigations initiated and completed since the last visit and included serious injuries and other serious incidents. 21. Sample D.3: three of seven (43%) discovered injury investigations for Individuals #280, #427, and #543 22. Sample D.4: ISPs for Individuals #102, #167, #394, #690, and #715 23. Security Camera Operator logs documenting residential/work area inspections 24. Standardized educational materials regarding abuse/neglect reporting 25. Sample C.3: the sample of Individual Support Plans (ISPs) reviewed. These were the ISPs that were

	part of Sample C.1 (Eleven crisis intervention restraints involving eight Individuals). 26. List of employees who failed to report or were late in reporting since the last review 27. Under Reporting Audit reports January - June, 2014 28. QA/QI committee meeting minutes: January – June, 2014 29. DFPS/OIG/Facility Quarterly meeting minutes 2/27/14 and 6/22/14 **People Interviewed:** 1. Nancy Condon, Facility Director 2. Deb Salsman, Director of Incident/Risk Management 3. Jeron Dotson, Incident Management Coordinator 4. Jeremy Clay, Security Camera Monitor 5. Traven Brown, Security Camera Monitor 6. Tyrone Nash, Assistant Director of Competency Based Training 7. Ten Direct Care Professionals (DCPs) **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 7/21/14 and 7/23/14 2. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 7/22/14 3. Facility Monthly Trends Meeting 7/24/14 4. Mortality Action Plan Review Meeting 7/23/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section D, in conducting its self-assessment, the Facility: • Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data (if used), as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included the Section D DADS Monitoring Tool o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Sample sizes were generally 20% of the N. The sample sizes were adequate to consider them representative samples. o The monitoring/audit tools did have adequate written instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools:

	Incident Management Coordinator and IMC Investigators. ○ 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). ○ Some external review of Section D data was done by QA staff but did not include inter-rater reliability using the Section D Monitoring Tool. The results of QA staff review of components of Section D were not included in the self-assessment. • For the most part, the Facility presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Presented findings based on specific, measurable indicators and used these data in initiating corrective actions. ○ Measured the quality as well as presence of items. ○ Some presentation of data was inconsistent. For example, for Provision D.2.a the self-assessment reports timely reporting as 100% in one section and 82% in another with no explanation as to the difference. ○ Some self-assessment compliance ratings were inconsistent with the data presented in the self-assessment. For example, Provision D.3.f was self-assessed as being in compliance but the "results of the self-assessment" section includes the following language: "included the investigators reasons for his or her conclusions were not always clear." There was no explanation if this was the case for all 15 investigations reviewed as part of the self-assessment or if not how many of the fifteen. • The Facility rated itself as being in compliance with 21 of 22 Provisions of Section D. The Monitoring Team found the Facility to be in compliance with 20 Provisions. There was one Provision where the Facility self-assessed itself as being in compliance and the Monitoring Team was unable to confirm compliance. This was Provision D.2.a (allegations/serious incidents being reported within required timeframes). For Provision D.3.i (disciplinary and programmatic actions following an investigation) the Facility self-assessed itself as not being in compliance and the Monitoring Team concurred. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve continued compliance. • Actions were reported as completed or in progress. • Maintenance activities for Provisions already in compliance were identified in the Action Plan. • The Facility data identified areas of needed improvement. The Facility's defined processes for auditing the administrative requirements associated with Section D compliance appeared to be sufficient to conduct future self-assessments The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. The Action Plan included 26 specific action steps which adequately targeted activity necessary to address those Provisions not yet in compliance.

	For those Provisions determined to be in noncompliance by the Monitoring Team, the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The Facility rated itself as being in compliance with 21 of the 22 Provisions of Section D. The Monitoring Team found the Facility to be in compliance with 20 Provisions which was an improvement from the 16 noted by the Monitoring Team in its last report. The two Provisions remaining out of compliance were Provision D.2.a (timely reporting of allegations of abuse/neglect) and D.3.i (completion of recommended actions following investigation review). The Facility had made significant improvement in both the conduct of its own investigations and its review of DFPS investigations compared to that observed at the last review by the Monitoring Team. This led to substantial compliance for Provisions D.3.f, D.3.g, and D.3.h. There was only one Provision where the Facility self-assessed compliance and the Monitoring Team did not. This was Provision D.2.a (allegations/serious incidents being reported within required timeframes). Late reporting of allegations of abuse, neglect, and serious incidents still occurs too often. 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 during this review. The number of confirmed findings of abuse and neglect had decreased from 15 to nine, comparing the two most recent six-month periods. The Facility continued two excellent practices noted by the Monitoring Team in its last report: 1) taking additional steps to protect the integrity of testimonial evidence by implementing a "Testimonial Evidence Acknowledgment Form", and 2) putting screen saver slides reinforcing abuse and neglect reporting on computers used by Direct Care Professionals (DCPs). The audit procedure required by DADS to detect under-reporting of significant incidents had been in place at the Facility and was being administered correctly. Improvement in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs) was evident. The Monthly Trend Meeting (a component of the QA program) was an important element of this process.

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D1</td><td>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.</td><td>The parties agreed the Monitoring Team would conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance. The Monitoring Team reviewed the Facility policy governing abuse and neglect and confirmed the policy explicitly prohibits abuse or neglect and that staff are required to report abuse or neglect.

As a result of this review this Provision remained in substantial compliance.</td><td>Substantial Compliance</td></tr>
<tr><td>D2</td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

According to data the Facility provided to the Monitoring Team, the numbers of abuse/neglect/exploitation allegations for the past two six-month periods were:

<table><tr><th></th><th>7/1/13 to 12/31/13</th><th>1/1/14 to 6/30/14</th></tr><tr><td>Total abuse allegations</td><td>58</td><td>79</td></tr><tr><td>Physical</td><td>47</td><td>65</td></tr><tr><td>Verbal/Emotional</td><td>11</td><td>14</td></tr><tr><td>Abuse confirmed</td><td>12</td><td>8</td></tr><tr><td>Physical</td><td>7</td><td>5</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Verbal/Emotional	5	3
Abuse inconclusive	1	4
Physical	1	3
Verbal/Emotional	0	1
Total neglect allegations	39	32
Neglect confirmed	3	1
Neglect inconclusive	0	7
Total exploitation allegations	1	1
Exploitation confirmed	0	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:

	7/1/13 to 12/31/13	1/1/14 to 6/30/14
Deaths	5	14
Serious Injuries	42	18
Sexual Incidents	1	1
Suicide Threat (credible)	6	2
Unauthorized Departure	7	6
Choking	9	8
Other	6	2

Based on the Monitoring Teams' review of DADS revised policies, including Policy 021.3 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 11/5/13: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.5 on Incident Management, dated 11/5/13: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

According to Facility policy CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) staff were required to report abuse, neglect, and exploitation within one hour by calling the DFPS 800 number and reporting to the Facility Director/designee. This was consistent with the Settlement Agreement requirements.

With regard to unusual/serious incidents, the Facility policy entitled CMGMT-01A (Abuse Neglect and Exploitation) and CMGMT-01B (Incident Management) required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to call the Facility Director/designee. This policy was consistent with the Settlement Agreement requirements.

#	Provision	Assessment of Status	Compliance
		The Monitoring Team interviewed two Security Camera Monitors to confirm their training in abuse and neglect and their acknowledgement that identifying and reporting questionable interactions between staff and Individuals as possible abuse or neglect was within their scope of responsibilities. Both were very knowledgeable of appropriate and inappropriate interactions between staff and Individuals and knew to report any interaction that might be perceived as abuse or neglect and had in fact done so. In order to evaluate staff knowledge in the area of abuse and neglect reporting, the Monitoring Team asked ten DCPs a series of questions. The 10 staff were selected by the Facility from a list provided by the Monitoring Team. Each response was evaluated by one member of the Monitoring Team, the Facility's Director of Incident/Risk Management, and the Facility's Settlement Agreement Coordinator. Consequently, for each question, responses were subjected to 30 evaluations (ten individuals' times three raters). Based on responses to questions, ten direct support professionals provided satisfactory responses to the following questions as noted: "There are two representatives that should be contacted immediately if you suspect or witness abuse/neglect/exploitation. Name them." Nine of 30 responses were evaluated as satisfactory (30%). This compares to the 46% reported to a similar question in the last review. "What is the reporting procedure and timeframe when abuse/neglect is suspected?" Twenty-seven of 30 responses were evaluated as satisfactory (90%). This compares to the 46% reported to a similar question in the last review. "What is the reporting procedure and timeframe for other serious incidents?" Fourteen of 30 responses were evaluated as satisfactory (47%). This compares to the 75% reported in the last review. The above data suggests the Facility needs to continue focusing efforts on improving staff 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 last report the Monitoring Team noted that in its self-assessment the Facility reported that late reporting was identified in 6% of 140 UIRs examined. This represented 11 instances of late reporting. For this review period the Facility reported in its self-assessment that late reporting was identified in 18% of 123 UIRs examined. This represented 22 instances of late reporting. For these 22 instances of late reporting the Facility noted that the source of late	

#	Provision	Assessment of Status	Compliance
		reporting was staff (4), Individuals (6), family members (2), and anonymously (10). The Facility did not present data that would enable a calculation of the percentage of incidents reported by staff that were reported timely. Doing so would be helpful in measuring the severity of the problem of staff not reporting timely. As reported by the Monitoring Team below from its Samples D.1 and D.2 the problem of late reporting was significant. The Facility continued to maintain nearly 100 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 screen saver slides are displayed. Several 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). Based on a review of the 14 investigation reports included in Sample D.1: ▪ For 10, the date/time of the incident was unknown so it could not be determined if it was reported in accordance with policy. ▪ Of the remaining four, none (0%) 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 43075722 (inconclusive physical abuse), 43144839 (unconfirmed physical abuse), 43056736 (confirmed physical abuse), and 43109627 (confirmed physical abuse). As reported above, the Facility self-assessment reported a much lower rate of late reporting than that noted from the Monitoring Team's sample, which showed 100% of the four allegations were not reported timely.. ▪ Of the remaining four, none (0%) 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 43075722 (inconclusive physical abuse), 43144839 (unconfirmed physical abuse), 43056736 (confirmed physical abuse), and 43109627 (confirmed physical abuse). ▪ For the three instances of late reporting noted by the Facility, evidence provided to the Monitoring Team confirmed recommendations for corrective action occurred in three cases (100%). ▪ For three of the four investigations noted by the Monitoring Team that were reported late (75%) there was evidence of follow-up on the part of the Facility. The exception was 43109627 as the Facility did not identify the late reporting in their review of this investigation. Based on a review of five investigation reports included in Sample D.2: ▪ Three (60%) showed evidence that unusual/serious incidents were reported	

#	Provision	Assessment of Status	Compliance
		within the timeframes required by DADS/Facility policy. UIRs 130 and 134 did not. ▪ Three (60%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. UIRs 130 and 134 did not. The Facility did have a standardized reporting format. Based on a review of 19 investigation reports included in Samples D.1 and D.2, 19 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. The Facility continued to review and investigate non-serious injuries that could be viewed as suspicious in nature. The purpose of these reviews/investigations was to rule out abuse/neglect, or, if abuse/neglect could not be ruled out to report the injury incident to DFPS for investigation. Sample D.3 (three such investigations) was reviewed by the Monitoring Team and these injury investigation were all found to be thorough and complete. In one of these three cases, abuse/neglect could not be ruled out, resulting in it being reported to DFPS for investigation. 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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. In reviewing Sample D.1 (DFPS investigations) in each case where an alleged perpetrator could be identified, the alleged perpetrator was placed in NDC (No Direct Contact) status. Additionally, where appropriate, additional measures were taken to support the alleged victim of abuse/neglect such as a psychologist administering an emotional assessment. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	In reviewing staff training records (Sample C.3) 23 of 24 (96%) employees had completed abuse/neglect training within the last 12 months. Additionally, the DADS report "Percent of All Employees Completing Courses of Training Program" report showed a 98% completion percentage for abuse/neglect training. In order to evaluate staff knowledge in the area of abuse and neglect recognition ten Direct Care Professionals were asked a series of questions. The 10 staff were selected by the Facility from a list provided by the Monitoring Team. Each response was evaluated by one member of the Monitoring Team, the Facility's Director of Incident/Risk Management, and the Facility's Settlement Agreement Coordinator. Consequently, for each question, responses were subjected to 30 evaluations (ten individuals' times three raters). Based on responses to questions, ten direct support professionals provided satisfactory responses to the following question as noted: "Name two signs or symptoms of abuse, and of neglect." Twenty-three of 30 responses were evaluated as satisfactory (77%). Based on this review this Provision was in substantial compliance.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement 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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. In reviewing staff training records (Sample C.3) 23 of 24 (96%) employees had properly completed the DADS form used to comply with this Provision. The one that did not was signed but not dated. As reported in Provision D.2.a: ▪ For the three instances of late reporting noted by the Facility, evidence provided to the Monitoring Team confirmed recommendations for corrective action occurred in three cases (100%). ▪ For the four investigations noted by the Monitoring Team that were reported late for three (75%) there was evidence of follow-up on the part of the Facility. The exception was 43109627 as the Facility did not identify the late reporting in their review of this investigation. ▪ In summary, in each instance (100%) where late reporting was identified by the Facility it took appropriate follow-up corrective action.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review this Provision was in 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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. The Facility continued to use standardized educational materials which it sent to each legally authorized representative (LAR)/guardian prior to each annual ISP meeting. In reviewing Sample D.4 the Monitoring Team determined that abuse/neglect awareness and reporting responsibilities was a regular part of each ISP meeting. Based on this review this Provision was in substantial compliance.	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 conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance. The Monitoring Team confirmed the Facility continued to conduct regular inspections of residential and work areas by Security Camera Operators to ensure posters were maintained in good order or replaced. The Facility was able to show the Monitoring Team documentation associated with these inspections. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. In reviewing Sample D.1 (DFPS investigations) all (100%) incidents were referred to law enforcement as appropriate. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good	The parties agreed the Monitoring Team would conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	In reviewing the subject of retaliation with 10 Direct Support Professionals (Sample C.3) all (100%) were aware retaliation was not tolerated and knew who to report it to. Additionally, when interviewed by the Monitoring Team Facility administrative staff reaffirmed their commitment (reinforced in policy and staff training) that retaliation would not be tolerated. The OIG investigator interviewed by the Monitoring Team reported occasionally staff hinted at possible retaliation but he was unaware of any actual retaliation as having occurred. One of 14 (7%) DFPS investigations in Sample D.1 made note of a concern of possible retaliation. This was the case with investigation 43075722. Apparently the employee who reported the alleged abuse late told the DFPS investigator she reported late because she was concerned about retaliation. When this investigation was reviewed by the Facility the Facility Review Authority recommended the effected employee receive individualized training in Facility policy provisions regarding perceived or actual retaliation. This recommendation was documented on the form the Facility Review Authority uses to record its review and recommendations associated with each DFPS case. It was not recorded on the accompanying UIR and the Monitoring Team was unable to determine whether or not this recommended training occurred. The UIR Recommendation Tracking Log also did not note this recommendation. The tracking log did note that action will be taken with the employee for late reporting. Based on this review the Monitoring Team determined this Provision remained in compliance in that temporary failure to comply during a period of otherwise sustained compliance does not constitute failure to maintain substantial compliance. To remain in compliance the Facility will need to demonstrate at the next review that any information that comes to its attention with respect to perceived or actual retaliation is appropriately acted upon.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for 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 Monitoring Team confirmed that the administrative review processes that were initiated to demonstrate compliance with this Provision remained in place during this review period. The substantial compliance finding from the last review stands.	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		

#	Provision	Assessment of Status	Compliance
	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 recently hired a new investigator who was in the process of being trained. The new investigator had not been assigned to conduct any investigation. As a result of this review this Provision was in substantial compliance.	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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. In reviewing Samples D.1 and D.2 the Monitoring Team did not identify any instances of lack of cooperation with investigations with outside entities. Additionally, the Monitoring Team interviewed an OIG investigator who reported no significant issues with cooperation of Facility staff. His primary concern was staff getting to interview appointments on time. This concern was also expressed by a DFPS investigator when interviewed by the Facility's Assistant Independent Ombudsman as part of the Facility's self-assessment for this Provision. In response to these concerns the Facility reported it was now implementing corrective action (i.e. administrative discipline) in instances where an employee does not show up for an interview or is inexcusably late for an interview. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	investigations completed by law enforcement agencies so as not to interfere with such investigations.	compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. In reviewing Samples D.1 and D.2 the Monitoring Team did not identify any instances of lack of coordination with investigations with outside entities. Sample D.1 included five cases where the investigation of the reported allegation was coordinated between DFPS and OIG. Based on this review this Provision was in substantial compliance.	
	(d) Provide for the safeguarding of evidence.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. In reviewing Samples D.1 and D.2 the Monitoring Team did not identify any instances of investigations being affected because physical evidence was not properly safeguarded. 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 previous reviews 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. Based on this review this Provision was in substantial compliance.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being	Based on Facility policy CMGMT-01B (Incident Management) investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident;	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	▪ Did require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. The Facility had made significant improvement in both the conduct of its own investigations and its review of DFPS investigations than that observed at the last review by the Monitoring Team. <u>DFPS Investigations (Sample D.1)</u> The following summarizes the results of the review of DFPS investigations: • 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 investigatory activity which typically 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. • Twelve of 14 (86%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; • For the two that were not completed within 10 days, two (100%) had documentation of a written extension request that had been approved by the DFPS Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. • Therefore, 14 of 14 (100%) were either completed within 10 days or received an appropriate extension. • Fourteen (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the	

#	Provision	Assessment of Status	Compliance
		basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • DFPS concerns and recommendations for corrective action were included in five investigation reports and were appropriate to address issues identified by the DFPS investigator. <u>Facility Investigations (Sample D.2)</u> The following summarizes the results of the review of Facility investigations of serious incidents: Five of five (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing the UIR and determining the time of the first entry indicating any on site work activity by a facility investigator. Five of five (100%) were completed within 10 calendar days of the incident (or had an approved extension), including sign-off by the supervisor with documentation of the extraordinary circumstances that necessitated the extension. Five of five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are presented in Provision D.3.f of this report. In all five of the investigations reviewed (100%), recommendations for corrective action were included. In all five of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation. 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. 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	Based on the Monitoring Team review of DADS revised Policy 021.3 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 11/5/13: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. The Facility had made significant improvement in both the conduct of its own investigations and its review of DFPS investigations than that observed at the last review	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	by the Monitoring Team. <u>DFPS Investigations (Sample D.1)</u> The following summarizes the results of the review of DFPS investigations: • In 13 out of 14 investigations reviewed (93%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. This was not the case for investigation 43075722. In the "Probable Version of Events" section of the investigation report an important concluding sentence reads, "It is difficult to determine what happened after point, due to efficient evidence." The Monitoring Team was unable to interpret this statement to determine if the investigation provided a clear basis for its conclusion. In this case the investigation of alleged emotional/verbal abuse and physical abuse resulted in an inconclusive disposition. • The report utilized a standardized format that set forth explicitly and separately: o In 14 (100%), each unusual/serious incident or allegations of wrongdoing; o In 14 (100%), the name(s) of all witnesses; o In 14 (100%), the name(s) of all alleged victims and perpetrators; o In 14 (100%), the names of all persons interviewed during the investigation; o In 14 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 14 (100%), all documents reviewed during the investigation; o In 14 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 14 (100%), the investigator's findings; and o In 13 (93%), the investigator's reasons for his/her conclusions. Refer to case 43075722 above. <u>Facility Investigations (Sample D.2)</u> The following summarizes the results of the review of Facility investigations: • In five of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o In five (100%), each unusual/serious incident or allegations of wrongdoing. o In five (100%), the name(s) of all witnesses (staff involved). o In five (100%), the name(s) of all alleged victims and perpetrators.	

#	Provision	Assessment of Status	Compliance
		○ In five (100%), the names of all persons interviewed during the investigation. ○ In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. ○ In five (100%), all documents reviewed during the investigation. ○ In five (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. ○ In five (100%), the investigator's findings. ○ In five (100%), the investigator's reasons for his/her conclusions. Facility QA staff conducted UIR Monthly audits of a sample of UIRs. The Monitoring Team reviewed four and noted these audits were a useful tool and helpful in ensuring all Facility investigations met the requirements of the SA. Based on this review the Facility was in compliance with this provision.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. The Facility had made significant improvement in both the conduct of its own investigations and its review of DFPS investigations compared to that observed at the last review by the Monitoring Team. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ 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; ▪ Fourteen of 14 (100%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation. ▪ The Facility Director/Incident Management Coordinator did accept (meaning did not formally question DFPS further) at least ninety-four percent of the investigations over the six months prior to the onsite review. Issues ancillary to the allegation DFPS investigated were often identified and stimulated an additional Facility investigation. The Monitoring Team views this as a good practice. ▪ For one (7%) 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility's data, the Facility did not note the problems with the investigation and/or report for investigation 43075722, and did not return the investigation to DFPS for reconsideration. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Five of five (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. ▪ In five of five investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ For five (100%), the supervisor had identified concerns, most being non-substantive technical corrections. For these investigations, for five (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. • For the five investigations noted above, the Monitoring Team did not identify any deficiencies in investigation methodology or conclusions. Based on this review this Provision was 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 meet the requirements outlined in Section D.3.f. This Provision was in substantial compliance.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. For investigations in Samples D.1 and D.2 in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented in all cases (100%). For investigations in Samples D.1 and D.2 for which recommendations for programmatic action were made, the following was found: • For 5 of 19 (26%), prompt and thorough programmatic action had been taken and documented on the UIR Recommendation Tracking Log. Those that did	Noncompliance

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		included DFPS investigations 43091794, 43166203, 43113370, and 43056736; and for Facility investigations UIR 167. • 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. Additionally, 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. In summary, for the 19 investigations in Samples D.1 and D.2, a total of 99 recommendations (disciplinary and programmatic actions) were made and 66 (67%) were noted on the UIR Recommendation Tracking Log as having been completed. In its last report the Monitoring Team noted that 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. This continued to be the case. While the IMRT considers and accepts or provides a reason for not accepting recommendations in the DFPS or UIR reports, they did not appear to assertively take action to see that accepted recommendations were carried out to their conclusion. Generally, the IMRT identified the timeframes in which actions should be taken, which were reasonably based on the seriousness of the issue and the time necessary for the action to be completed, but it was not clear that the IMRT regularly monitors these timelines. For the most part in accepting recommendations, the IMRT did not identify the expected outcomes (e.g., competency of staff, modification of a physical environment, changes in practices, reduction in an at-risk behavior, etc.). This did, however, occur if a set of recommendations became the foundation for a formal Corrective Action Plan pursuant to QA policy. The Facility did not appear to have a system to confirm that expected outcomes were achieved, and to document 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). Again, if a set of recommendations became the foundation for a formal Corrective Action Plan pursuant to QA policy, this did occur. The Facility system for post investigation implementation of recommendations had not as yet matured to the point that it could regularly 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	

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		modified. 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 conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. In reviewing Samples D.1 and D.2 the Monitoring Team determined records of the results of every investigation are maintained in accordance with the requirements of this Provision.	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 incidents and investigations, the Facility did have a system that allowed tracking and trending by: ▪ Type of incident; ▪ Staff alleged to have caused the incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. Over the past two quarters, the Facility's trend analyses: ▪ Were conducted at least quarterly; ▪ Did address the minimum data elements; ▪ Did use appropriate trend analysis procedures; ▪ Did provide a narrative description/explanation of the results and conclusions; and ▪ Did, as appropriate, contain recommendations for corrective actions. The Facility had consistently convented Monthly Trends Meetings. Those attending were in large part also members of the Facility QA/QI Council. At this meeting data related to unusual incidents, abuse/neglect allegations and investigations, injuries, and restraints were presented and discussed. Based on a review of Monthly Trend Meeting minutes, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified and an action plan was needed, action plans were usually developed. The use of data in this regard had noticeably improved from that observed during the last review by the Monitoring Team. There were	Substantial Compliance

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		several good examples where this process had led to a formal Corrective Action Plan (CAP) that led to improved conditions. For example, trend data review showed an alarming number of injuries in one residential building. A Corrective Action Plan was developed, implemented, and evaluated over a six month period. Trend data showed a significant decrease in injuries following implementation of the Corrective Action Plan. In its last report the Monitoring Team noted that Improvement was needed in using tracking and trending data to initiate, implement, and evaluate Corrective Action Plans (CAPs). This improvement had occurred. Based on this review this Provision was in substantial compliance.	
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 conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance. The Monitoring Team confirmed with the Facility Director, Director of Incident/Risk Management, and the Incident Management Coordinator that the established statewide practices associated with background checks of perspective and current employees and volunteers remained in place.	Substantial Compliance

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. DSSLC Section E Presentation Book (undated) 4. DADS Policy 003.1 - Quality Assurance 5/22/13 5. DSSLC Policy CMGMT-15 Quality Assurance 2/1/13 6. List of Facility policies that contain a QA component (undated) 7. DSSLC QA Plan (including monitoring and key indicator matrix) 5/5/14 8. Quality Assurance/Quality Improvement Council meeting minutes since the last review 9. Facility Trends Monthly Meeting minutes January-June, 2014 10. Residential Services Management Team monthly report June, 2014 11. Monitoring tools and guidelines for each provision of the Settlement Agreement (SA) used by QA department (various dates) 12. Monitoring tools used by departments/disciplines 13. Corrective Action Plans (CAPs) initiated since the last review 14. CAPs completed since the last review 15. CAP tracking logs and related documentation 16. Residential Services Management Team meeting minutes 5/15/14 and 5/29/14 **People Interviewed:** 1. Lori Powell, Director of Quality Assurance **Meetings Attended/Observations:** 1. Incident Management Review Team (IMRT) 7/21/14 and 7/23/14 2. Quality Assurance/Quality Improvement Council (QA/QI Council) meeting 7/22/14 3. Monthly Trends meeting 7/24/14 4. Residential Services Management Team (RSMT) meeting minutes 5/15/14 and 5/29/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment, the Facility reviewed the QA policy, data inventory lists, the QA plan and matrix, the monitoring tools used by the QA department as well as those used by other departments including inter-rater reliability checks, and QA/QI Council activities. The Facility QA Department did not use any specific monitoring tools in assessing compliance with Section E. For the most part the Facility presented data in a meaningful/useful way. A notable exception was that the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by

	departments and disciplines. As noted in its last report the Monitoring Team continued to observe that different departments and disciplines were at different stages of QA implementation. The QA self-assessment should be more detailed describing implementation status by department/discipline. The Facility did not appear to have a comprehensive monitoring tool to assess its progress towards implementing its QA program and meeting all requirements associated with Section E. The Facility rated itself as being in compliance with Provisions E.2 and E.3 of Section E. The Monitoring Team determined the Facility was in compliance with Provisions E.3 and E.4. While the Facility had administrative processes in place that would lead to compliance with Provision E.2, they had not as yet all been implemented. 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 as descriptive as described to the Monitoring Team by the QA Director during the course of the review. As noted in the last report by 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 actions that need to be taken by departments/disciplines necessary to complete Facility-wide actions. In this regard the Facility described three specific steps to address Section E compliance: • 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. • Develop a system to modify CAPs based upon effectiveness and compliance monitoring. • QAQI Council minutes will include effectiveness of the CAPs for the Council to review and approve. For those Provisions determined by the Monitoring Team to be in noncompliance, the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: It was evident to the Monitoring Team that the Facility had made substantial progress since the last review. The basic administrative framework for a dynamic QA program was in place. All Provisions of the SA had inter-rater reliability associated with monitoring and auditing tools. 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. Additionally, the system for the development and tracking of Corrective Plans, including the evaluation of their effectiveness was noticeably improved from that observed at the last review by the Monitoring Team. Although significant progress had occurred since the last review, full and complete implementation of data collection, review, and analysis had not as yet been achieved. 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 could be examined for most data points. There remained a need to improve submission of QA Matrix plan data to the QA department as scheduled. Key indicators were better defined than observed at the last review. For the most part it was possible to measure improvement or regression in the metric described in the key indicator. 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 were exemplary. They were extensive and provided much useful data for review, analysis, discussion, and decision-making. Additionally, section leads also prepared narrative information for each report that included, 1) accomplishments for the last three months, 2) upcoming challenges and plans for overcoming these challenges, 3) data analysis, 4) review of corrective action plan(s), 5) status of policy/procedure review, revisions, and implementation, 6) summary of any relevant committee recommendations, and 7) priorities for the next quarter. The Monitoring Team found the organization of these reports to be very user friendly. The QA/QI Council reviewed each section of the SA at least once a quarter. Additionally, the Facility had implemented a Monthly Trends Meeting in which data associated with incidents, injuries, and restraints were reviewed; and a monthly Residential Services Management Team (RSMT) report which provided the RSMT (the Director of Residential Services and the Unit Directors) extensive detailed data related to topics unique to things happening, or not happening, on the residential units. 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. There was an adequate system for tracking the status of CAPs and a regular review of CAP status at the monthly QA/QI Council meetings. Since the last review the Facility had developed a system for evaluating the effectiveness of CAPs. This system was still in the early stages of implementation at the time of this review and has the potential to lead to substantial compliance in the near future.

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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.	The Facility had made substantial progress since the last review. The basic administrative framework for a dynamic QA program was in place. All Provisions of the SA had inter-rater reliability associated with monitoring and auditing tools. 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. Additionally, the system for the development and tracking of Corrective Plans, including the evaluation of their effectiveness was noticeably improved from that observed at the last review by the Monitoring Team. <u>Facility QA policies and practices</u> There were facility policies that adequately supported the state policy for quality assurance. The Facility had a Quality Assurance/Quality Improvement (QA/QI) Council required by State policy. Additionally, many other Facility policies contained a QA component within them that complemented the over-arching Facility policy. 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. Since the last review use of inter-rater reliability had expanded to include all sections of the SA. There was a complete and adequate data list/inventory at the Facility and the list was current. The inventory was maintained by the QA Director and was regularly reviewed. The QA plan narrative at the Facility had been updated in May, 2014. The plan was comprehensive and addressed 15 distinct elements of the QA program at the Facility. These included: ▪ a description of the purpose of the QA program, ▪ The organizational structure of the QA process (including individual roles and responsibilities), ▪ A definition and description of the QA matrix, ▪ A description of monitoring protocol, including sample sizes, ▪ A description of auditing protocol, including sample sizes, ▪ A description of Facility data bases used in implementing the QA plan, ▪ requirements associated with the Facility data list/inventory, ▪ A description of the components of key indicators and clinical indicators, ▪ Requirements for data analysis, ▪ Requirements for inter rater reliability,	Noncompliance

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		▪ Description of the role of quarterly Section Lead meetings, ▪ Description of the content of the QA report, ▪ A description of various Facility committees that are part of the QA program, ▪ Description of the QAQI Council and its role in reviewing data and guiding the entire QA process, and ▪ Description of the corrective action planning and implementation process The QA plan matrix contained the data to be submitted to the QA department; these data are then included in QA reports and presented to the QA/QI Council. The Facility's QA Plan matrix consisted of two separate matrixes. One described the monitoring/auditing requirements associated with the use of monitoring tools for all 19 sections of the SA (one is not required for Section E). The other described the data review and process for key/clinical indicators which had been developed to date. There were at least some key/clinical indicators for each of the 19 sections of the SA (one is not required for Section E). 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%). This consisted of 56 distinct indicators some of which addressed multiple SA Sections. In sum, 92 indicators were applied across the 19 sections of the SA as noted below:	

Section	# of Indicators
C	5
D	6
F	4
G, H, L	19
I	4
J	5
K	3
M	16
N	2
O/P	8
Q	5
R	2
S	8
T	2
U	2

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		V 1 For these 19 Sections of the SA, both process and outcome indicators were identified for 14 (74%). This compares to the (37%) reported in the last report by the Monitoring Team. For the remaining five Sections, either process or outcome indicators were provided; thus, the Facility had identified either process or outcome indicators, or both, for 19 of 19 Sections (100%). Of these, in 19 of 19 (100%), the indicators provided data that could be used, if appropriate, to identify the information specified in requirements for Provision E1: trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services: areas of care; individual staff; and/or Individuals receiving services and supports, as necessary and appropriate to each key indicator. The Facility's data system had achieved a level of maturity such that multiple variables could be examined for almost every data point. 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. The QA plan matrix included all self-monitoring tools and self-monitoring procedures. All data that QA staff members collect were listed on the matrix. All of the items in the QA plan matrix also appeared in the QA data list/inventory. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that of the 50 data items in the QA plan matrix (not including key indicators), 38 (76%) 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 were: • FSA Assessment of Assessment • PNMP Audit • Mealtime Monitoring • PNMT Assessment Audit • Assessment of Assessment • Universal Monitoring • Treatment Sheet Audit • Preferences/ Strengths/ Needs Audit • Planning for Movement • Post-Move Monitoring	

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		• Alternate Discharges • Timeliness of CLDPs The QA Director attributed this to some items not being in use for a full six months and others undergoing revision. The reports prepared by the QA department for the QA/QI Council were exemplary. They were extensive and provided much useful data for review, analysis, discussion, and decision-making. Additionally, section leads also prepared narrative information for each report that included: 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 Monitoring Team found the organization of these reports to be very user friendly. Additionally, the Facility had implemented a Monthly Trends Meeting in which data associated with incidents, injuries, and restraints was reviewed; and, a monthly Residential Services Management Team (RSMT) report which provided the RSMT (the Director of Residential Services and the Unit Directors) extensive detailed data related to topics unique to things happening, or not happening, on the residential units. Of the 50 items in the QA plan matrix, 38 (76%) 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 are noted above. The QA Plan Matrix included 50 items. The QA Plan Narrative contained 15 components. At the time of the review, of the 65 items/components of the QA plan narrative and QA plan matrix, the Facility implemented 58 (89%). The seven components of the QA Plan matrix/narrative that were not fully implemented were five monitoring tools for Sections O and P of the SA which were undergoing revision and full implementation of the QA plan provisions for CAPs and Committee meetings. In its last review the Monitoring Team noted that in developing Corrective Action Plans (CAPs) the Facility struggled with developing data-related problem statements from which action steps could be articulated and improvement measured. This was much improved from that observed at the last review. Documentation and observation indicated that QA staff assisted each discipline in analysis of data. The QA Director and Settlement Agreement Coordinator met monthly with each SA Section Lead for this purpose.	

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		Of the 50 self-monitoring tools for the SA, the content of 50 (100%) appeared to be appropriate and the QA Director reported all 50 (100%) were reviewed within the past six months and revised as appropriate. For example monitoring tools for Sections O and P of the SA had undergone revision since the last review. Of the 50 self-monitoring tools for the SA, 45 (90%) had adequate formal written instructions and guidelines for the user (this compares to the 44% reported in the last review by the Monitoring Team). This consisted primarily of written prompts on the monitoring tool. The Facility reported that inter-rater reliability checks were used to determine if the instructions on the tools were adequate and if not the instructions would be modified to provide greater clarity. Most others had at least some instruction included on the self-monitoring tool but in many cases theses instructions were not complete and comprehensive. The tools that did not have adequate instructions were: • Section M: Documentation of UTI • Section M: Antibiotic Therapy • Section M: Vomiting • Section M: Documentation of Pre-Treatment and Post-Sedation • Section M: Urgent Care/ ER 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 50 self-monitoring tools for the 19 sections of the SA (one is not expected for Section E), 43 (86%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-rater reliability). This compares to the 34% noted in the last report by the Monitoring Team. Those that did not included five tools related to Sections O and P of the SA which had undergone revision and two monitoring tools for Section T which had only recently been implemented. 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 and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for 19 (100%) of the 19 sections. Based on this review the Monitoring Team determined this Provision was not in compliance; however, the Facility had made substantial progress since the last review.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of	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.	Noncompliance

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	corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	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 the indicator being measured. As reported in Provision E.1 the Monitoring Team noted several deficiencies that potentially affect the accuracy of data and, therefore, potentially impact the Facility's ability to analyze data regularly as required in this Provision. These include: • Five of 50 (10%) monitoring tools lacked adequate instructions for the users of those tools. • Seven of 50 (14%) monitoring tools were not implemented according to the frequency specified in the QA Plan. • Data associated with 12 of 50 (24%) monitoring tools were not being reviewed monthly by the QA Department. 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: • A review of the data listing inventory and matrix, • Discussion of data and apparent outcomes, • A review of the conduct of the self-monitoring tools, • The creation of corrective action plans as appropriate, • A review of previous corrective action plans. Since the last onsite review, data were available during these meetings to facilitate department/discipline review and analysis with QA staff; however, as noted in Provision E. the Facility reported that 43 of 50 (86%) monitoring tools used by the Facility had either n been in use for the full six month period or had undergone revision resulting in limited dat review. As a result in some areas there was not sufficient longitudinal data available to facilitate meaningful review and analysis. The reports prepared by the QA department for the QA/QI Council were exemplary. They 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 Monitoring Team found the organization of these reports to be very user friendly.	

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		Of the 20 sections of the SA, all 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the SA that were presented, 20 of 20 (100%) contained the following components: • Self-monitoring data (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate) • Key indicators (reported for a rolling 12 months or more and broken down by program areas, living units, work shifts, etc., as appropriate). • Narrative analysis There was an adequate description of the QA/QI Council in the QA plan narrative and in a separate QA/QI Council policy/ procedure document. 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: 1. Accomplishments for the last three months. 2. Upcoming challenges and plans for overcoming these challenges. 3. Data analysis 4. Review of Corrective Action Plan(s) 5. Status of policy/procedure review, revisions, and implementation 6. Summary of any relevant committee recommendations 7. Priorities for the next quarter Agendas were structured so that each Section of the SA was reviewed at least once every three months. Additionally, the Facility had implemented a Monthly Trends Meeting in which data associated with incidents, injuries, and restraints was reviewed; and, a monthly Residential Services Management Team (RSMT) report which provided the RSMT (the Director of Residential Services and the Unit Directors) extensive detailed data related to topics unique to things happening, or not happening, on the residential units. The second QA/QI Council meeting of the month was referred to as the "business 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	

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		significant impact on Facility operations, or budget and personnel management issues. Minutes from six of six (100%) QA/QI Council meetings since the last review indicated that the meeting occurred according to schedule. These data relate to the formal QA/QI Council meetings and do not include the "business meeting" or Monthly Trends Meeting referenced above. Minutes from six of six (100%) QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, These data relate to the formal QA/QI Council meetings and do not include the "business meeting" or Monthly Trends Meeting referenced above. Minutes from six of six (100%) QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. These data relate to the formal QA/QI Council meetings and do not include the "business meeting" or Monthly Trends Meeting referenced above. Minutes from six of six (100%) QA/QI Council meetings since the last review documented that (a) data from the QA plan matrix (key indicators, self-monitoring) were presented, (b) data were trended over time, (c) comments, interpretation, and analysis of data were presented. These data relate to the formal QA/QI Council meetings and do not include the "business meeting" or Monthly Trends Meeting referenced above. In six of six (100%), recommendations and action plans were developed. These were select when appropriate to do so, and were based on the data presented. These data relate to the formal QA/QI Council meetings and do not include the "business meeting" or Monthly Trends Meeting referenced above. 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. In the meeting data review led to discussion which led to decision-making and action planning. A spirit of teamwork was evident to the Monitoring Team. The Facility processes for initiating, implementing, and tracking CAPs had become more organized than that observed the last review. An adequate written description did exist that indicated how CAPs are generated, including the criteria for the development of a CAP. Generally, CAPs were required when monitoring data showed performance indicators were not at, or had dropped below, a pre-determined threshold (for example, 85%).	

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		When considering the full set of CAPs, they did appear to have been chosen following the written description policy or procedure. Of the 15 CAPs reviewed by the Monitoring Team, 15 (100%) appeared to appropriately address the 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. CAPs were not, however, always developed for issues which data suggested a need for a CAP. For example, as noted in Provision D.2.a of this report, timely reporting of incidents appears to be a significant problem at the Facility yet no CAP was initiated to address this. Similarly, as noted in Provision D.3.i, following up on investigation/IMRT recommendations appears to be a significant problem at the Facility yet no CAP was initiated to address this. Based on a sample of 15 CAPs: • 15 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • 15 (100%) included the anticipated outcome of each action step. • 15 (100%) included the person(s) responsible. • 15 (100%) included the time frame in which each action step must occur. Based on this review this Provision was not in substantial compliance. Significant progress had occurred since the last review but full and complete implementation of data collection, review, and analysis 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: • 15 (100%) included documentation about how the CAP was disseminated. • 15 (100%) included documentation of when each CAP was disseminated. • 15 (100%) included documentation of to whom it was disseminated, including specific person(s) responsible. 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 QA/QI Council meetings. Based on this review this Provision was in substantial compliance.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely	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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	manner, to meet the desired outcome of remedying or reducing the problems originally identified.	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. Since the last review the Facility had developed a process to determine (and document) whether or not a CAP had been implemented fully and in a timely manner. Based on a review of all four CAPs that had been completed since the last review all four (100%) had been implemented fully and timely, including periodic review by the QA/QI Council while implementation was in process and a final review by the QA/QI Council when the CAP had been completed, including at the time specified in the CAP for a final review to determine the effectiveness of the CAP. Based on this review this Provision was in compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Since the last review the Facility had developed and implemented a systematic method to assess the effectiveness of a CAP and modify a CAP accordingly. Features of this system included: 1. When a CAP is developed the CAP describes in measurable terms the expected outcome of the CAP, for example, "a reduction in injuries in home xyz." 2. As the CAP is implemented predetermined relevant data is to be recorded at monthly intervals. 3. If after implementation of CAP action steps data does not begin to show a downward trend the CAP is to be modified. The QA Director and QAQI Council review CAP data monthly. 4. After the CAP is closed (i.e. "fully implemented") data continues to be recorded for the period of time specified in the CAP, for example "three months after CAP closure." These more longitudinal data are used to ultimately determine the effectiveness of the CAP. 5. This process is monitored by both the QA Department and the QAQI Council. This system was still in the early stages of implementation at the time of this review. The Monitoring Team believes this system, once fully operationalized over a period of time, should lead to compliance with this Provision. The Monitoring Team looks forward to reviewing these improvements at the next review. Based on this review this Provision was not in compliance.	Noncompliance

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated: 07/03/2014 2. Denton State Supported Living Center Action Plans, CV8 (undated) 3. Denton State Supported Living Center Report for Monitors, dated July 21st, 2014 for Compliance Visit 8 4. Section F Presentation Book materials 5. DADS Policy 018.2: Most Integrated Setting, dated 10/18/2013 6. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 7. DADS Policy 017: Habilitation, Training, Education, and Skill Acquisition Programs, effective, 8/01/2013 8. 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 9. DSSLC Policy CMGMT 03: Integration Of Clinical Services, dated December 1, 2013 10. DSSLC Policy CM-14: At Risk System, effective 6/20/2014 11. QIDP Roster, dated June 23, 2014 12. An alphabetical list of each individual at the Facility, with the most recent ISP meeting date, the date on which the ISP document was completed/filed, and the date of the previous ISP meeting date 13. Over the last one-year period, a) the total number of ISP meetings held; b) the total number of ISP annual meetings that occurred more than 365 days after the previous annual meeting; and c) the total number of ISPs that were filed more than 30 days after the annual ISP meeting was held 14. ISP Meeting Attendance, 01/01/2014 to 05/31/2014 15. Section F Self-Assessment: Tracking spread sheet for assessments due 12/01/2013 through 06/01/2014 16. ISP assessments for Individuals #78, #151, #182, ##474, #483, #642, #772 and #791 17. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #78, #151, #182, ##474, #483, #642, #772 and #791 18. Monthly Reviews for Individuals #78, #151, #182, ##474, #483, #642, #772 and #791 19. Individual Support Plans (ISPs), ISP assessments, Monthly Reviews and Skill Acquisition Plans (SAPs) for newly admitted individuals: Individuals #7, #511, #584 and #586 20. QA/QI Data Meeting, Section F, dated May 27, 2014 **People Interviewed:** 1. Tony King, Qualified Intellectual Disabilities Professional (QIDP) Coordinator 2. Julie Kuester, QIDP Educator 3. Lori Powell, Director of Quality Assurance 4. Dora Tillis, Assistant Director of Programs **Meeting Attended/Observations:** 1. Annual ISP meetings for Individuals #113, #638, and #667 2. ISP Preparation Meeting for Individual #235

	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. 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 collected through the Facility's QA/QI processes, which was a substantive improvement over previous self-assessments for purposes of objectivity and long-term sustainability. 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. The Monitoring Team was very much impressed with the comprehensive approach taken in the development of the Self-Assessment for Section F, including the attention paid to the previous non-compliant findings by the Monitoring Team, as well as the effort taken to integrate the document with the related Action Plans such that staff could visualize the results of the self-assessment and the specific action plan(s) to address any identified deficiencies. The Facility is to be commended for this thoughtful and detailed effort. The Monitoring Team encourages the Facility further to define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. Once it develops provision-specific outcome indicators, the Facility should review the Action Steps to ensure they are focusing on those activities most likely to support the identified outcomes. 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. Completion of an Action Step should take into account whether the outcome has been met; if not, the Action Step should be continued or modified instead, based on the analysis of the outcome indicators. For example, for Provision F1a, the Facility indicated in its Action Plans that it was developing a curriculum in the following areas to teach the QIDP's to become competent facilitators that focused on six topics, including person centered planning overview, preferences and strengths, goal development, living options, the Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plan (IHCP), and rights. Several of these, including person centered planning overview, preferences and strengths and goal development were designated as completed, but there was no clear methodology established to indicate what the expected measurable outcome of the training was, how it was measured, and whether the intended results had been achieved. In this case, the Monitoring Team found there was continued need for improvement in these areas, suggesting that the "completed" Action Step required additional attention. The Facility indicated that its Self-Assessment resulted in findings of noncompliance in all sub-provisions of Section F, except for Provision F1b, which relates to the requirements for IDT composition and participation. The Monitoring Team concurred with the overall assessment of noncompliance, but was not able to agree with the assertion of compliance with Provision F1b.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. The assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. A summary of noted progress included: The Facility had begun implementing a significant effort to improve on its processes to

	better support individual understanding of and participation in the ISP process resulting in continued improvement in actual meeting participation by individuals. The Facility had expanded upon and formalized a previous Corrective Action Plan to encourage a fuller discussion of Community Living Options at annual ISP planning meetings. An ISP Compliance Workgroup had also been formed to begin working with individual IDTs starting with the ISP preparation meeting and following through until completion of the ISP meeting, including post ISP preparation of documents and monitoring of the plan for the first three months. **Provision F1:** This provision was not in compliance. No changes had been made to ISP format and process but considerable training and coaching continued to be provided to the QIDPs and IDTs. Overall, however, the Facility 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 also remained concerned with the Facility's development of the ISP in accordance with the Americans with Disabilities Act (ADA) and Olmstead decision. **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. Some progress was noted in the use of preferences and skills in Action Plans, however. 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. The Facility was to be commended for its continued efforts toward developing a comprehensive quality assurance system for this Section, including, for example a recently implemented change to its tracking and notification procedures, including a weekly Pre-Delinquency and Delinquency List provided to all Departments for attention and follow-up, which appeared to show significant early improvements in timeliness of ISP completion. These processes were continuing to develop; based on the outcomes at this time, it was not yet clear the processes were effective in terms of identifying and remediating issues that would ensure ISPs are developed and implemented consistent with the provisions of this section.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		

#	Provision	Assessment of Status	Compliance
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. <u>Staffing of QIDP Department</u> The Facility reported that it had 29 QIDP positions, including six Lead QIDPs. There were also a recently hired QIDP Coordinator, a Facilitation Coordinator, and a QIDP Educator. All individuals had an assigned QIDP. The average QIDP/individual ratio was reported to be 1:16, although it was noted that the range was fairly wide. As of June 23, 2014, according to the QIDP Roster, at least two staff, including the Facilitation Coordinator, were serving as QIDP for 30 individuals or more. This was anticipated to be a temporary situation until vacant positions could be filled. <u>Process of determining competency of QIDPs in the facilitation process</u> Based on the list provided and additional information provided by the Facility following the compliance visit, four of the 29 QIDPs (14%), the QIDP Coordinator, QIDP Educator, and the Facilitator Coordinator had been deemed fully competent in facilitation. 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. Additional progress was noted over the previous site visit in some areas. • For none of the eight ISPs reviewed (0%) did the facilitation process result in an adequate discussion of the most integrated setting, but improvement was noted. See Provision F1e. • For three of three ISPs annual meetings observed (100%) the facilitation process resulted in improved participation of the individual. See Provision F1b. • For none of the eight 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. 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 eight 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. Conclusion: This provision was found to be not in compliance.	Noncompliance
F1b	Consist of the individual, the	<u>Composition and Participation of IDT:</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. During the ISP Preparation meeting, the policy 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. The Monitoring Team was unable to adequately evaluate participation at the ISP Preparation meetings as only two of eight (25%) recent ISPs had been preceded by an ISP Preparation meeting. This was a disappointing outcome, as it also made evaluation of attendance by required IDT members impractical. The Facility provided a document entitled ISP Meeting Attendance 01/01/2014-05/31/2014 that provided ISP attendance data for various IDT members. It was unclear how the Facility was able to accurately track the Total Meetings Required, as indicated below, given the lack of ISP Preparation meetings described above.	

Discipline	Total Meetings Required	Attendance	Compliance
Active Treatment Staff	43	35	81%
Behavioral Services/designee	142	131	92%
Communication Therapist (Speech)/designee	185	176	95%
Day Programming	136	113	83%
Dental	5	2	40%
Diabetic RN/ED	1	1	100%
Dietitian/Nutritionist	126	103	82%
Direct Support Professional (DSP)/BC/HLT	216	216	100%
Facilitator	31	31	100%
HRO	1	1	100%
Individual	216	196	91%
LAR/Family/Advocate	209	167	80%
Music Therapist	1	1	100%
Nursing	216	214	99%
Occupational Therapist/Designee	216	211	98%
Ombudsman	6	6	100%
Physical Therapist/ Designee	216	212	98%

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Physician	216	197	91%
Placement Coordinator	5	5	100%
Psychiatrist	102	90	88%
QDDP	216	216	100%
Skin Integrity Nurse	4	4	100%
Transition Specialist	32	30	94%
Vocational Services	93	86	92%
Total = attended/ required	2634	2444	93%

The Monitoring Team did review the signed attendance sheets for the eight recent ISPs. Of the two individuals (Individuals #151 and #182) that had ISP Preparation Meeting documentation identifying the required members for the ISP annual planning meeting, neither (0%) had all required members actually participate. It was noted, in particular, that the ISP Preparation Meeting identified by name the appropriate DSPs that should attend, based on their familiarity with the individuals, but there was no DSP participation in these two meetings. Overall, five of eight (63%)
ISPs reflected DSP participation.

While it was not possible to evaluate compliance with required attendance at annual ISP planning meetings for this sample, overall it appeared that meetings were well attended, at least in terms of the number of members participating. One positive finding was that individuals were present at 100% of the ISP annual planning meetings.

On the other hand, the Monitoring Team also reviewed the available attendance signature sheets for the ISP addendum (ISPA) meetings for this group and found these were generally not as well attended and did not consistently appear to include participation by all appropriate members. Six of the individuals had a total of nine ISPAs, and attendance signature sheets were provided for eight of these. Only two of eight (25%) included participation by a DSP or other residential representation, even in cases in which this would seem imperative. For example, for Individual #474, it became necessary to change rooms during the night due to aggression on the part of the individual's roommate and it was noted the "team agreed" this move should be made permanent. The only participants in this meeting were the LAR, the QIDP and the psychologist. No representative of the residence was in attendance to discuss the nature of the issue and whether any additional protections might be needed in the home. It was also noted that there was limited participation by individuals in the ISPA, as only two of six (33%) of individuals who had ISPA participated in the meetings.

<u>Extent of Individual participation in ISP:</u>

#	Provision	Assessment of Status	Compliance
		There was continued improvement in actual meeting participation by individuals as noted in Provision F1a above. For three of three (100%) ISP annual meetings observed during this monitoring visit, there was some progress noted with the IDT involving the individual. The Facility had begun implementing a significant effort to improve on its processes to better support individual understanding of and participation in the ISP process. DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, Exhibit K: Increasing Individual's Participation at Their Own ISP Meeting, dated 5/17/13, described the process as follows: 1) Each individual will have an ISP preparation meeting {ISP Prep) three months before the scheduled ISP meeting. 2) Prior to the ISP Prep meeting a Preferences & Strengths Inventory (PSI) will be conducted with the individual. 3) The ISP Prep meeting will discuss necessary items in preparation for the ISP meeting including discussing options to ensure the individual participates/contributes to the development of their own ISP. "How the person is going to be involved at the ISP meeting should be the first thing discussed."· 4) The options, as guided by the individual's previously identified abilities, to increase participation in the ISP process will be defined by the individual and/or the team members who know the individual best. 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. 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, needs and goals they may have. The goal of this process was to ensure the individual and the team work together in developing a service plan that is person centered. All QIDPs had received training related to this process. In addition, a prompt had been added to the ISP Preparation summary template to ask "How is the person going to be involved at the ISP meeting." This prompt also initiated a process for informing Life Skills and/or Active Treatment Tech (ATT) to assist the person in preparing for their ISP meeting over the next several months. The Monitoring Team commended this overall. For three of three (100%) ISP annual planning meetings attended by the Monitoring Team during this visit, it was observed that materials specific to individuals preferences and relationships, such as scrapbooks, were available and used with varying degrees of efficacy in terms of promoting the participation of individuals. The most effective use was observed for Individual #113, who was able to use the scrapbook to show the IDT important people and places of interest. The Monitoring Team discussed with members of the	

#	Provision	Assessment of Status	Compliance
		Section F team some additional methods that might be used in the future to expand upon this effort and make it more meaningful for individuals, but considered this a very positive step forward. Conclusion: 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.	Extent to which assessments are conducted routinely: Policy: 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." 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 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 little evidence the IDTs had been routinely making use of these processes for annual ISPs to ensure needed assessments were completed on a timely basis. The Monitoring Team had requested the most recent completed ISP from each residence at the Facility and chose a random sample of ten of these for review. One of the ten was completed prior to the timeframe for this monitoring, and another was a new admission, so these were excluded for the purposes of evaluating the timeliness of assessments. Only two of the remaining eight (25%) included the ISP Preparation document intended to define the assessments that were to be completed. Of the six ISPs that did not include the ISP Preparation documentation, five included a written notation from the Facility that an ISP Preparation meeting had actually not been held. As a result, the Monitoring Team was unable to assess whether all required assessments were present. The Facility was able to track whether discipline specific assessments that were present were completed at least ten working days prior to the ISP	Noncompliance

#	Provision	Assessment of Status	Compliance

annual planning meeting, but the lack of ISP Preparation meeting documentation meant the Facility did not have an adequate basis to be able to accurately track whether all required assessments were submitted, or submitted on a timely basis.

Assessments for the ISP were also still not routinely completed on a timely basis, but overall there was continuing improvement noted. The Facility provided the following data by discipline in its Self-Assessment, for assessments due 12/01/2013 through 06/01/2014 represented in the table below:

	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	**Avg**
Life Skills	97%	94%	100%	95%	96%	96%	**96%**
Audiology	100%	83%	88%	61%	53%	96%	**80%**
OT/PT	94%	90%	93%	96%	92%	98%	**94%**
Vocational	74%	96%	100%	87%	92%	92%	**90%**
SAM	85%	89%	78%	86%	85%	77%	**83%**
Speech	100%	96%	96%	100%	98%	90%	**97%**
Dental	100%	87%	90%	86%	90%	90%	**91%**
Pharmacy	97%	100%	100%	100%	100%	100%	**100%**
Psychology	59%	53%	64%	64%	89%	98%	**71%**
Medical	87%	79%	79%	92%	90%	100%	**88%**
FSA	59%	56%	74%	55%	58%	69%	**62%**
Nursing	85%	93%	85%	87%	83%	89%	**87%**
Nutrition			24%	5%	0%	32%	**15%**
Totals	86%	85%	82%	78%	79%	87%	**83%**

Other findings related to timeliness of assessment included:

- In the sample of eight ISPs completed prior to the monitoring visit, none (0%) had all required assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. In several instances, some assessments were still not completed until after the meeting was held. Overall for this sample, the rate of timeliness was 68%, which was slightly below the 73% at the time of the previous monitoring visit. As noted above, it was still generally not possible to ascertain assessments that might be missing altogether, as only 25% of these had ISP Preparation meeting documentation that prescribed the required assessments; therefore this assessment is based on whether available assessments only were

#	Provision	Assessment of Status	Compliance
		completed prior to ten working days before the ISP annual meeting was held. • As reported in Provision K5, DSSLC had made only slight progress in ensuring that Psychological Evaluation reports were completed in a timely manner. Although some progress was noted in intellectual assessments, a substantial decline was noted in the provision of timely adaptive skill assessments. Only three of 10 individuals (30%) had been provided with a current adaptive skill assessment. This reflected a decrease of 57% in comparison with the previous site visit. Only three of 10 individuals (30%) had been provided with a current assessment of intelligence. Although better than the previous site visit, this reflected far less than an adequate provision of assessments. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs/ assessments are conducted in response to significant changes:</u> 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: • 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. • DSSLC had also developed an assessment of assessments for the FSA summary completed by the QIDP and completed random audit for one Functional Skills Assessment/Summary per QIDP per quarter to ensure adequate evaluation of the individual's functional skill level. Progress continued to be noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included: • For Provision M2, which requires the Facility to update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status, the Facility was found to be in substantial compliance. • As reported in Provision J6, he Monitoring Team review found that, although substantial compliance was not yet achieved, the quality of psychiatric evaluations continued to improve, particularly in the area of diagnostic justification. • As reported in Provision R2, this provision was found to be in substantial compliance. Individuals identified as having decreased communication were provided with comprehensive assessments or screenings that would identify the need for further assessment.	

#	Provision	Assessment of Status	Compliance
		• As reported in Provision P1, most required components of OT/PT assessments were completed, but there was a lack of identification of a schedule for monitoring. All areas were noted to have continued improvement with the exception of the identification of the monitoring schedule. Despite this 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: Provisions J6, K5, K6, L1, O2, O8, P2, S1, 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. QIDP staff continued to be responsible for completing the PSI process, as described in DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013. The Monitoring Team observed that the PSI was not being developed in a rigorous manner. Examples included: • For only one of eight (13%) recent ISPs did the PSI not contain many one-word and/or NA responses. • The PSI for Individual #667 prepared for this year's annual planning meeting was virtually identical, with only few exceptions, to last-year's version, including many NA and Unknown answers. • For Individual #235, whose ISP Preparation planning meeting was held during this monitoring visit, preferences and strengths were discussed at the meeting, but the PSI was not available at the meeting. No other related materials were provided. • As described in Provision F2f below, PSIs were developed on a timely basis for none of four (0%) new admissions reviewed. <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> 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. There was some progress noted in this regard. For example, as reported in Provision P2, skill acquisition programs were now recommended in the OT/PT assessments. Eleven of 15 (73%) were found to be represented as part of the ISP. This was a noted improvement since the previous review. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were still not consistently completed in time for QIDPs to complete the ISP Guide five days	Noncompliance

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		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: • 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. • As reported in Provision S1, based upon the information submitted by the Facility, it was not evident that assessments were consistently used in the development of SAPs for the majority of individuals living at the Facility. Furthermore, there was no indication of substantive improvement in the use of assessments in comparison with the previous site visit. For example: o ISPs for only three of 10 SAPs (30%) reflected evidence to support the reviewed SAP. o Functional Skill Assessments (FSAs) for only four of 10 SAPs (40%) 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 60% of the reviewed SAPs, however, it was not evident that the FSA had been effectively used in the development of skill acquisition programs. • Also reported in Provision S1, of the 10 individuals included in the sample, only three (30%) had been provided a formal assessment of adaptive skills. In none of the 10 records (0%) was there indication that the formal assessment of adaptive skills was used in formulating teaching programs. • As reported in Provision O2, for zero of four individuals (0%), all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, • As further described in Provision F2a1, preferences and strengths identified in the PSI were not yet effectively incorporated into the ISP and Action Plans. <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> 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. • Of the eight ISPs reviewed, for none (0%) did all of the discipline-specific	Noncompliance

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		assessments include the applicable statement/recommendation. Of the 77 total assessments that were reviewed, however, 72 (96%) included a determination of whether the individual could be served in a more integrated setting. This was evidence of progress in this area. • Of the 77 total assessments reviewed, however, only 14 (19%) included substantive recommendations for how the individual's needs could be met in a more integrated setting. Statements were often fill-in-the blank templates and 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 individualized and 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. • Of seven recent ISPs for which a referral was not current at the time of the ISP annual planning meeting, six (86%) included an independent recommendation from the professionals on the team to the individual and LAR. Of the seven ISPs, each (100%) provided some discussion of the protections, services and supports that would be needed by the individual in the most integrated setting, but these were compromised by the lack of substantive recommendations in the discipline assessments. • 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, although the Facility was developing strategies to address this issue. As also described in Provision T1b2, IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. • In 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 not an adequate discussion or rationale provided for why the individual opinions were not reflected in the IDT's independent recommendation. For examples, For Individual #791, the annual ISP indicated the facility discipline members, (independent of the resident and LAR/family) determined the individual could not be served in the community at this time due to LAR Choice. This indicated this particular IDT, at least, did not comprehend its responsibility to provide an independent professional determination prior to considering the issue of LAR choice. 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	

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		integrated setting, and plans to overcome such obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example: • None of six (0%) completed ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. • In none of three (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. • Three ISP annual planning meetings were attended during the on-site visit and there was discussion of community living options observed in each; however, the Monitoring Team found, as described in Provision T1b1, that the living options discussion for Individual #667 did not adequately identify or address the obstacles. • The Monitoring Team also remained concerned about the IDT's treatment of the living options for Individual #228, whose ISP annual planning meeting was observed at the time of the previous planning meeting. At that time, the IDT asked the individual on several occasions and in several different ways if he was interested in moving to the community and the individual indicated yes to each. The IDT did not respond appropriately to the indications of interest, reminding the individual repeatedly of previous statements of disinterest. 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 the individual's actual preference. This was a disservice to the individual, who 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. The Monitoring Team observed at this monitoring visit that the IDT had not since taken any assertive action to make a further determination of the individual's interest or preferences and this individual had made no community tours. As it relates to this provision, there was some 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. 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. The IDTs at DSSLC were much more consistently including in the ISP a discussion of the supports, services and protections that would be needed in the most integrated setting even if the IDT ultimately chose not to make a referral. This 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	

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		services and supports is also prerequisite to assisting the team to identify and address potential obstacles to movement. Improvements were still needed, however. The Monitoring Team remained 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, and often assessments did not provide such information. In addition, there remained a tendency on the part of the IDTs 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. As reported in Provision T1b2, the Monitoring Team observed the Facility had undertaken some initiatives to improve outcomes in this area. A Corrective Action Plan (CAP) had been initiated in December 2013 to encourage a fuller discussion of Community Living Options at annual ISP planning meetings. This CAP was discontinued and is now instead an ongoing process in which QA, CFR and/or Transition Specialist staff attend ISP's and offer consultation regarding the Community Living Options discussion. The consulting staff also were to provide reminders/prompts during the discussion as needed. This was reported to be a positive experience, although only one referral had thus far resulted from any of the meetings attended. In addition, staff had received training on the development of ISP Action Plans to address obstacles related to individual and LAR reluctance. The Monitoring Team commends the Facility for these thoughtful approaches. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
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	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of	Noncompliance

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	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;	needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. <u>Identification and Use of Individuals' Preferences and Strengths:</u> In the review of eight recently completed 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 annual ISP planning meetings, although the Monitoring Team remained concerned that the PSI process, as it is currently implemented, was not adequate for identifying preferences and strengths. See Provision F1c. The Monitoring Team did observe some Action Plans and Service Objectives related to identified preferences. Some continued to be formulated in a generic manner, i.e. will go on community outings "consistent with preferences," but some were more thoughtful and specific. Overall, eight of eight (100%) incorporated preferences to a degree in the Action Plans, but none (0%) were observed to have done so in a thorough and effective manner. 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. Action Plans to address strengths were not yet consistently observed, but there was improvement. For example, for Individual #483, it was reported one of the individual's strengths was an appreciation for being given responsibility and Action Plans developed included developing independence in work, leisure and household skills. The Monitoring Team had observed in its previous report that IDTs might want to consider some additional approaches to identifying strengths as this appeared to be more difficult for them than identification of preferences. Questions might include: • What is the individual good at? • What do people like about the individual? • What is your favorite thing about the individual? • What can/does the individual contribute to friends, family, community? • What special talents does the individual have? It was noted that staff receiving Person Centered Training had begun working with individual IDTs to teach them how to develop a one page profile for each individual that considers the	

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		following: a) What do people like about the individual b) What is most important to the individual and c) How to best support the individual. This was a positive step. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed:</u> The Monitoring Team found that none of the eight 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. As described in an example in Provision F2a4 below, the practice of setting all completion dates at one year from the date of the annual ISP planning meeting was one indication that IDTs were not yet prioritizing needs in an effective manner. 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 six (0%) recent ISPs reviewed in which a referral was not made evidenced proficiency in this regard. Also see Provision F1e above. <u>Identification of Supports Needed to Encourage Community Integration</u>: There was little progress noted in identification of supports for community integration, in that three of eight (38%) 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 only one (13%) of the Action Plans actually indicated any requirement for a minimum frequency of implementation in the community. This was consistent with findings reported in Provision S3b that specific guidelines for community SAP training were inadequate. None of 42 submitted SAP data collection forms (0%) included any instructions specific to community implementation. For this sample of eight recent ISPs, the Monitoring Team was able to confirm from the documentation provided that a SAP had been implemented in the community in only one instance for one individual (Individual #772). As further reported in Provision S3b based upon a review of SAP data collection sheets, there was not a pattern as to the community implementation of SAPs. One individual had only one instance of a SAP implemented in the community in three months (Individual #765), while other individuals were provided as many as nine instances of community SAP implementation in the same time period. 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 often calling for the outings to be	

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		consistent with individual's preferences. For three of eight (38%) ISPs, the ISPs did provide at least one specific destination for a community activity, and for only one of eight (13%), for Individual #182, described any activity that would promote the actual integration of the individual with others living in the community. 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 into 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. Conclusion: This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Extent to which ISP specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet needs: For none of eight (0%) recent ISPs reviewed, did the IDTs consistently develop a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs and overcome barriers to living in the most integrated setting. 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. Objectives were not yet consistently measurable. For example, as reported in Provision P2, a goal for Individual #617, simply stated to "increase range of motion"; this did not provide the IDT information that would permit it to determine when the goal or objective is met or when lack of progress would indicate a need to revise the intervention. Adequacy of processes for identification of and plans to overcome barriers to living in the most integrated setting: 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	Noncompliance

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		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 six (0%) recent ISPs reviewed in which a referral was not made evidenced proficiency in this regard. Also see Provision F1e above. Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. Adequate integration can be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, integrated health care plans, etc.,) in a measurable way into the ISPs through, for example, measurable objectives; • Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; • Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary 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. There was some progress noted. For example: • As reported in Provision J8, the Monitoring Team observed an ISP meeting for Individual #280, and found the behavior analyst and psychiatrist worked together very effectively to present an integrated summary of that care to the overall IDT and LAR.	Noncompliance

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		• As reported for Provision R3, integration of the communication assessments into the ISP had shown improvement as evidenced primarily by improved comprehensiveness of the PNMP and statements regarding how staff can better bridge any gaps in communication. 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 eight 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. Additionally, as reported in Provision J8, only six of 20 (30%) IRRF statements provided information that provided integrated case formulation that supported a quality PSP. <u>Conclusion</u>: This provision was found to be not in compliance. Overall, additional training was still needed to prepare teams to think creatively about the needs and preferences of individuals and how to address them on a person-by-person basis in a way that involves collaborative planning and recognition of the possible contributions of several disciplines to an area of need and/or preference.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Adequacy of methods for implementation:</u> The Facility did not yet consistently identify adequate methods for implementation, but there were some indications of progress. Examples of improvement found in Section S included: • Ten of the 10 reviewed SAPs (100%) reflected a potentially adequate documentation methodology. • Seven of the 10 reviewed SAPs (70%) reflected the opportunity for the target skill to be performed • Seven of the 10 SAPs (70%) included adequate instructions for staff. Continuing deficiencies in methods for implementation included the following: • 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 and sufficient trials for learning to occur. As a result, SAPs were still not tailored to the unique learning needs, current skills, or physical condition of each person. Examples for findings in Provision S1 indicated that: o None of the 10 reviewed SAPs (0%) reflected adequate behavioral objectives. Objectives should define the conditions under which the skill will be	Noncompliance

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		performed, the actions that constitute successful performance of the skill, and the criteria for measuring success. o None of the 10 reviewed SAPs (0%) reflected sufficient trials for learning to take place. o Two of the 10 reviewed SAPs reflected an adequate description of teaching conditions. <u>Adequacy of identification of time frames in action plans:</u> For eight of the eight ISPs reviewed (100%), action plans included timeframes for completion. However, action plan timeframes were not individualized and were not selected based on appropriateness for the individual or the need and activity or objective, but rather consisted almost universally of a standard (i.e. one year) completion date across the board. This was particularly troublesome when completion of one activity or task was required before others could be implemented. Such a situation should have called for the IDT to project an earlier timeframe for the initial task to be completed, such that the remaining task(s) could be completed before the year ended. There were also one-time actions for which an early completion date would have been beneficial to the overall delivery of supports and services to an individual, but completion dates were still set at one year out. For example, for Individual #474, the Action Plans called for a referral for an updated Speech assessment and for the development of an individualized communication book, because staff had noted a significant decrease in the individual's communication abilities over the past year. The frequency of implementation was one time and the completion date was one year from the date of the ISP annual planning meeting. Given how essential communication is to all other aspects of the individual's care and plan of active treatment, this need should have been prioritized to occur within a short timeframe. <u>Adequacy of identification of persons responsible in action plans:</u> The ISPs typically indicated by position who would be responsible for program implementation, documentation and data review. This did not appear to be sufficient to achieve the outcomes of ensuring program implementation was accomplished as required, however, as evidenced by the finding described above that methods of implementation were not adequately constructed by those identified as responsible for designing the specifics of the action plans. This was further evidenced by findings in Provision F2f which indicated that ISPs, including the completed Action Plans, were sometimes not being put into place on a timely manner by those identified as responsible for ensuring plan development. <u>Conclusion</u>: This provision was found to be not in compliance.	
	5. Provides interventions, strategies, and supports that effectively address	<u>Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings:</u> To establish compliance in this provision, IDTs must develop individualized action plans that	Noncompliance

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	the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	effectively address the individual's assessed needs for services and supports and 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. None of the eight 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 addition, As reported in Provision S3(a), progress had been made toward providing training that was practical and functional for individuals. At the time of the site visit; however, considerable weaknesses remained. Only four of the 10 sampled SAPs (40%) addressed specific needs reflected in formal assessments and only five of the 10 sampled SAPs (50%) targeted skills that would likely be useful for the individual. Progress was noted in practicality, as 90% of the SAPs reviewed were determined to be practical in several aspects. SAPs that tended to be impractical resulted from weaknesses in assessment or instructions that would have prevented the SAP from being implemented correctly. Conclusion: This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	<u>Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress:</u> The ISP did not consistently identify the specific data and/or documentation and frequency of data collection that would permit the objective analysis of an individual's progress. Examples included: • Ten of the 10 (100%) SAPs reviewed for Provision S1 reflected a potentially adequate documentation methodology. To assess whether the documentation methodologies were sufficient to produce adequate data collection, SAP data collection forms for the previous three months were reviewed for each SAP in the sample. For only three of the 10 SAPs (30%) were data collection forms available for all three months. Of the 21 available data forms, 13 (62%) reflected incorrectly recorded data and 14 (67%) had missing data. The majority of data forms reflected substantial errors. • As reported in Provision P2, monthly documentation from the OT and PT and/or QIDP 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. <u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u> For eight of the eight ISPs reviewed (100%), the Action Plans defined the person(s)	Noncompliance

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		responsible for data collection. Similarly, for eight of eight (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. Conclusion: 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.	Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP: 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. As another example, it was also reported in Provision R2 that Speech/Language Therapists (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 SLPs 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. 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 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. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and	Extent to which ISP is accessible to staff: As reported in Provision V1, the Active Records and Individual Notebooks were usually accessible. The Monitoring Team also asked 14 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	Noncompliance

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	comprehensible to the staff responsible for implementing it.	document that contained information about the individual and their programs. Twelve of the 14 (86%) of these staff were able to correctly identify where the ISP report was located. Extent to which ISP is comprehensible to staff: 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 eight ISPs reviewed, none (0%) appeared to be written in a manner that would facilitate the ability of staff to comprehend and implement it appropriately. For the ISP to be comprehensible to staff, it should be clearly written and organized to convey purpose, methodology and responsibility. 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. The Monitoring Team suggests DADS and the Facility consider a means to facilitate this understanding, such as providing more of a succinct narrative summary at the beginning of the ISP, so that staff, particularly DSPs, can envision the big picture and have a better understanding of what all the sections of information that follow are about and why they need to refer to them. The Facility continued to take and/or plan actions designed to promote comprehensibility of the ISP. As reported in Provision K11, DSSLC continued to require 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 records revealed that that the readability requirement was enforced by the peer review process. The Facility had also reported in the past 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 plans still had not yet been finalized but were still slated for implementation. There were still many instances in which staff could not describe supports contained in the ISP or did not implement them as called for in the ISP. Examples included: • As reported in Provision S1, the Monitoring Team conducted observations in a variety of settings across the Facility. These observations revealed that across all settings 45% of observed individuals were functionally engaged. • As reported in Provision R3, four of six staff interviewed (67%) were knowledgeable of the individual and their communication related programs Conclusion: This provision was found to be not in compliance.	

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F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	Monthly review of progress: The Facility required the 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 May 27, 2014 indicated the overall Facility compliance for the Monthly Review Audit had remained well below standard. The Facility had initiated a CAP in December 2013 to address the deficits in the QIDP Monthly Review. The documentation reviewed for this monitoring visit indicated the Facility still continued to experience difficulties in the implementation of QIDP Monthly Reviews, but there was some improvement noted. For eight recent ISPs, the Monitoring Team found the following: • Most of the Monthly Reviews did include graphs as to SAP progress, which was an improvement. • There were no absent Monthly Reviews, which was progress since the previous monitoring visit. • Sixteen of 24 (67%) Monthly Reviews were clearly completed on a timely basis, per the dated signatures of the QIDP. It was difficult to evaluate the actual timely completion of all monthly reviews as some were not signed and dated by the QIDP upon completion. This lack of timely monitoring made it impossible to revise programs or modify the ISP as needs arose. • Follow-up actions were often not documented, even when the QIDP stated a plan for follow-up action. For example, for Individual #642, an ENT referral was to be completed by 4/08/14, but each of the Monthly Reviews indicated only that the QIDP would follow up with the Primary Care Provider (PCP). • For some Monthly Reviews, little evaluative content was provided and/or the same information was repeated month after month. 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. For example: • As reported in Provision P2, for individuals with PNMPs or SAPs, for zero of six individuals (0%) there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly • As reported in Provision K4, progress notes for three of 10 behavior intervention programs (30%) were noted to reflect worsening behavior or other problems without a timely response from the program author or IDT. The ISP Preparation meeting should provide 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	Noncompliance

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		should be occurring. This process was not working as intended, as only two of the eight individuals included in the sample ISPs had ISP Preparation meetings held. Conclusion: This provision was found to be not in compliance.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	Policy: 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 individuals' ISPs must receive competency-based training on the implementation of the plans for which they are responsible prior to performing employment duties without direct supervision, and staff must receive competency-based training when the plans are revised. It also required that professional staff/designee will be responsible for providing competency-based training to staff responsible for implementation of the ISP. Extent and adequacy of competency-based training for staff responsible for development of ISPs: Training sessions for the QIDPs and other IDT members responsible for development of ISPs had been a focus of the Facility in recent months. • The QIDPs continued to meet monthly and receive updates and training on a variety of topics. • In April 2014, the Facility developed a training curriculum for all QIDP's on how to complete a thorough record review prior to the ISP Preparation Meeting and the Annual ISP planning meeting to ensure preparedness as well as identifying needs, concerns, gaps, and discrepancies. • In March 2014, the Facility developed an assessment of assessments for the Functional Skills Assessment (FSA)/Summary completed by the QIDPs, and followed that with the completion of a random audit for one FSA per QIDP per quarter to ensure adequate evaluation of the individual's functional skill level. While the Monitoring Team did observe continued 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: • 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	Noncompliance

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		measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> The Facility continued to work towards other competency-based training for staff responsible for implementation of ISPs. For example, as reported in Provision M4, there was continued substantial compliance. The Nurse Educators continued to maintain 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 reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed Overall, however, the Monitoring Team found staff were not yet adequately provided with competency-based training. Examples included: • As reported in Provision M5, two of eight (25%) individuals' IHCPs' Direct Support Professional Instruction Sheets included signatures verifying that they had been trained on all three shifts. • 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 nor did the Facility present documentation that certain PBSPs had been identified as requiring CBT for all staff working with a particular individual. The Facility did not present a measure or system for assessing the competence of staff in relation to challenging behaviors that occur infrequently. This finding was also influenced by the lack of active treatment and engagement observed and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record, although some progress was noted. See Provision S1 andO4 for examples. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare	<u>Extent to which ISPs are developed within 30 days of admission:</u> The Facility reported 17 admissions in the past six months. The Facility reported ISPs were held within 30 days of admission for all 15 individuals who had been at the Facility for 30 days as of the time the document request was completed. The Monitoring Team reviewed four of these. For all four (100%), the 30-day ISP meeting was completed within 30 days. For	Noncompliance

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	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.	these ISPs, 28 of 50 (56%) of the assessments were completed at least five days prior to the planning meeting as required. Three of four PSIs were present, but none (0%) were completed at least ten days prior to the planning meeting, a requirement intended to ensure the assessments reflected preferences and strengths. Of the three PSIs that were present, each was dated on the day of the ISP annual planning meeting, so they would not have been available to the clinicians for use in developing the discipline-specific assessments. Provision K7 also documented timeliness concerns, finding that within 30 days of admission three of 15 recently admitted individuals for whom documentation was reviewed (20%) were provided with adaptive skill assessments; seven of 15 recently admitted individuals (47%) were provided with intellectual assessments; 11of 15 recently admitted individuals (73%) were provided with behavior assessments; and 14 of 15 recently admitted individuals (93%) were provided with psychological assessment reports. <u>Extent to which ISPs are revised annually and as needed:</u> 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 6/01/2013-5/31/2014) was 519. Eight (2%) annual meetings were reported to have occurred more than 365 days after the previous annual meeting. <u>Extent to which ISPs are put into effect within 30 days of preparation:</u> Based on data from a State Office database, 157 ISPs had not been filed within 30 days of the ISP annual planning meeting over an eight month period between September 2013 and April 2014. The numbers between January 2014 and April 2014 showed an increasing trend of delinquency. In addition, the Self-Assessment for Section F indicated its process included a review of the Timeliness of ISP tracking by Quality Assurance to determine if ISPs were filed within 30 days of the ISP meeting from 12/01/2013 through 05/01/2014. These data indicated only 50% of ISPs were filed within a 30 day period. As a result, the Facility implemented a change to its tracking and notification procedures in June 2014, including a weekly Pre-Delinquency and Delinquency List provided to all Departments for attention and follow-up. The QAD noted this appeared to be making an impression on all parties, with significant early improvements as indicated by the shrinking numbers on each week's succeeding Delinquency List. 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. For example, for Individual #744, whose ISP was held on 5/23/14, no SAPs had been implemented as of 7/18/14. The Monitoring found timely implementation was also spotty in the four new admissions described above. <u>Conclusion:</u> This provision was found to be not in compliance due to the failure to implement	

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		ISPs to implement 30 day and annual ISPs within the required timeframes.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The Monitoring Team reviewed the Denton State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated May 27, 2014, 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: • Department and QA audits with the ISP Integrated Monitoring Tool. An ISP Compliance Workgroup had been formed to begin working with individual IDTs starting with the ISP preparation meeting and following through until completion of the ISP meeting, including post ISP preparation of documents and monitoring of the plan for the first three months. • CAPs as indicated by results of data collection and analysis. In May of 2014 CAPs were developed and implemented for monthly review of progress, SAP implementation, and ISP Preparation Meeting timeliness. • Analyzing trends in data • Auditing active treatment • Auditing composition and quality of ISPs, SAPs, etc. • Conducting observations of staff implementation of plans • Audits on timeliness of assessments • Audits of scheduling of annual ISP meetings • Audits of assessment quality • Audits in the homes to determine if staff are correctly implementing plans <u>Conclusion:</u> This provision was found to be not in compliance. The Facility was again commended for its efforts toward developing a comprehensive quality assurance system for this Section, including the integration of the ongoing QA/QI processes with the Self-Assessment for this Section. . 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. As noted in the Monitoring Team's review of the Self-Assessment, the Facility still needed to develop clear outcome indicators for each of the provisions.	Noncompliance

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. Presentation Book for Section G 4. Provision Action Information for Section G 5. DSSLC Policy Medical-01 Medical Care Exhibit G—Process for Consultations 7/1/13 6. DSSLC Policy CMGMT 03 Integration of Clinical Services 6/21/14 7. Quarterly data report for Sections G/H of 4/29/14 with data through March 2014 8. Sample of medical consultation reports for Individuals #18, #32, #88, #368, #731, and #744, and Modified Barium Swallow Studies (MBSS) for Individuals #82, #312, #351, #551, #590, and #749 9. Minutes of Integrated Morning Report (IMR) meetings for 6/2/14-6/6/14, 7/7/14-7/11/14, and 7/14/14-7/18/14 10. IMR audits of 5/21/14, 5/2/14, 6/16/14, and 6/24/14 11. Active Record for Individual #744 12. Physical and Nutritional Management Committee (PNMC) meeting minutes 12/1/13 to 5/31/14 13. ISP Meeting Attendance, 01/01/2014 to 05/31/2014 **People Interviewed:** 1. Nancy Condon, Facility Director, Stanley Call M.D., Director of Medical Services, and Dianne Tompkins, Health Status Compliance Coordinator (HSCC) **Meetings Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #638 2. ISP Preparation Meeting for Individual #235 3. Change of Status meeting for Individual #684 4. Physical and Nutritional Management Committee 7/24/14 5. Integrated Morning Report 7/23/14 and 7/24/14
	Facility Self-Assessment: 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 auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The Integrated Morning Report (IMR) audit tool

	▪ The Integrated ISP audit tool ▪ The Health Services Compliance Coordinator (HSCC) Medical Record audit ▪ External and Internal Medical Quality Assurance audits o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with requirements of Section G of the Settlement Agreement o The monitoring tools included adequate methodologies, such as review of documentation, including documents in Active Records, and observations of meetings. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. This sample sizes were adequate to consider them representative samples. o The Medical Director and staff physicians conducted internal Medical Quality Assurance audits. External Medical Quality Assurance audits were conducted by an external physician with quality assurance experience. The HSCC conducted IMR and Medical Record audits. An experience program auditor conducted ISP audits. 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 areas. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the Integrated ISP tool but had not been established for the other tools. ▪ Used one other relevant key indicator: o Attendance by clinical staff at ISP meetings. The Self-Assessment gave dates of 8/1/13 to 11/30/13, which would have been from the prior review period and were the dates given in the last Self-Assessment. However, the data differed and likely came from some part of the current review period. ▪ The Facility rated itself as being in compliance with Provisions G2. This was consistent with the Monitoring Team's findings The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed or In Progress. In addition, the Facility provided a list of ongoing activities; it was valuable to separate those from actions to be completed. ▪ The Facility data identified that integration, while improved, continues to need improvement. ▪ The actions provided a set of steps likely to lead to compliance with the requirements of this Section but did not provide all steps that might be necessary. Many of the completed actions had moved the Facility toward compliance, and many of the planned actions appeared appropriate and necessary. However, some actions should be viewed as part of a sequence rather than standing alone with no clear path toward compliance. For example, one action is for the "HTD to meet with QIDP Coordinator, RNCM Supervisor, and Director of Residential Services to develop a plan on how to ensure that the IDTs conduct and document discussion of all applicable areas effected or potentially effected by a change in an individual's PNM status." While this is an appropriate action,

	it is only one step; the Action Plan should identify additional steps needed to ensure action to address areas affected by this change in status is taken in an integrated manner, and the effectiveness of this action is assessed. One example in which the Action Plan began to do this involved integrating RN and PCP quarterly reviews; one action was to develop a system, and the next was to train and implement the system. Further actions might involve tracking to ensure it is implemented, assessing the quality of the integrated reviews, and determining whether the integrated reviews result in integrated health care planning.
	Summary of Monitor's Assessment: Considerable progress has been made in integrating clinical services, especially at a systemic level. Examples of lack of integration in clinical services to individuals continued to be found, but improvement was found overall. **Provision G1:** Collaboration and integrated planning continued to improve. Improvement in the format and participation in the Integrated Morning Report shows promise of establishing integrated planning as routine, as well as providing an excellent venue for integrated discussion and identification of issues needing collaborative planning. As reported before, the numerous interdisciplinary committees and workgroups provided means to address both systemic and individual issues in an integrated manner. The commitment to integrated planning at a systemic level was made evident by the participation of the Facility Director in PNMC. There were examples of excellent integrated planning for individuals, but also other examples in which this needed improvement. The Facility is approaching substantial compliance with the provision. **Provision G2:** Documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and observations of Integrated Morning Report meetings and review of minutes documented examples of follow up with IDTs, this provision is found to be in substantial compliance. Although consultation documentation did not indicate referral to the IDT, the Facility had an appropriate process in place to facilitate documentation of review of recommendations from non-facility clinicians through the IMR, and to make referrals to the IDT when appropriate.

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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	The Self-assessment reported this provision is not in substantial compliance but that integration is making progress in some areas such as attendance and participation in Morning Medical Meeting Report, ISP attendance, and review of QDRR by PCP. Improvement remained needed in timeliness of assessments. The Monitoring Team agreed with these findings and with the Facility's rating of noncompliance. Nonetheless, continuing improvement in integration of planning and clinical services continued to improve, such that substantial compliance might be achievable in the near future as these processes become consistently evident in	Noncompliance

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	therapy) to ensure that individuals receive the clinical services they need.	care of individuals. Policy 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 revision to the requirements for the Integrated Morning Report, changes to the Chronic Care process including a requirement for primary care providers (PCPs) and RN Case Managers to meet to review all individuals on a quarterly basis, role of the Review Authority to review all investigations, expansion of the Restraint Reduction Committee (now the Trends Analysis/Restraint Reduction Committee) to review trends, and the use of a Consult database. Integrated Morning Report The Facility continued to conduct the Integrated Morning Report meetings daily five days per week during business days. The Medical Director chaired the meeting. It was 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: • Provider On-Call Report • Infirmary Report • Hospital Report • Specific Departmental/Discipline Report (with specific reports on Tuesdays, Wednesdays, and Thursdays, such as Admissions and Transitions report each Wednesday—some are weekly, some scheduled on alternate or every third week) • Follow-Up Items: Individual • Follow-Up Items: Systemic (Wednesday, and more often as needed) • Additional Information Discussed The Provider On-Call report was documented in SOAP format. Many "A"s (assessment) sections simply stated "Differential Dx"; "P" (plan) was described in two cells—"Plans/Actions Taken by On-Call Provider" (which included report of actions already taken as well, in a few cases, of plans for further immediate actions planned) and "Comments/Plans from All" (which included a record of discussion during the meeting as well as actions to be taken by any discipline, when assigned). The Infirmary report had sections for SOP (no assessment). "P" was titled "Attending PCP Plan." There was also a cell for "Other" that included detailed information for some reports and documented some extensive discussions. It appeared that the dates	

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		identified for these cases were the dates individuals were admitted to the Infirmary. The Hospital report was in SOAP format and included "Discharge plans from hospital/Significant treatment changes." There was also a section on Attending PCP/All that provided additional info/review of discussion/additional plans by PCP. The section on follow up for individuals was always blank. Instead, follow up was reported in the reports regarding individuals in the Infirmary or Hospital sections. This kept all information about an individual case in one place. A significant change had occurred in the meeting process. The last compliance report stated that 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. Both meetings observed during this visit involved interdisciplinary discussions about the condition, care, and appropriate treatment for several individuals. In some cases, this discussion involved physicians, psychiatrist, nurse, dietitian, pharmacist, behavior analyst, and the Director of Consumer/Family Relations. For some individuals, these discussions led to identification of actions that needed to be implemented by several disciplines. Given the number of individuals served by the Facility and the number of individuals who were hospitalized, it was gratifying to see that the Facility managed to maintain this process in an efficient manner that allowed for substantive review and discussion of many individuals. Minutes of IMR meetings were detailed and comprehensive. They documented extensive discussion. In many cases, minutes documented that follow-up actions assigned at these meetings had been completed. It should be noted that minutes of open cases and issues were repeated until the case or issue was resolved, with new information added when discussed at the current meeting; thus, it was often difficult to determine what was new information at a particular meeting without reviewing prior minutes. Follow up regarding individuals included the following: • Minutes of the 7/14/14 meeting on-call provider report regarding Individual #335 reported on an IDT meeting held 7/11/14. • Minutes of the 7/14/14 meeting infirmary report for Individual #148 reported on an IDT meeting of 6/23 regarding the plan for when the individual returns home. Minutes of the 7/15/14 meeting infirmary report for Individual #148 stated the team met 6/23/14. • Minutes of the 7/14/14 meeting infirmary report stated on change of status meetings were to be held for Individuals #170 and #192. • The 7/14/14 and 7/15/14 hospital report stated for Individual #590 "IDT to meet Friday to review status and condition" due to family request for DNR. The	

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		minutes for the 7/15/14 meeting included an update that "The IDT met and no DNR requested." • Minutes of the 7/15/14 meeting regarding Individual #498 added the following information to 7/14 minutes, "C.O.S to meet and tracked in IMRT." • Minutes of the 7/15/14 meeting regarding Individual #134 stated "C.O.S to meet" and "C.O.S met 7/14/14 Tony to follow up with team and inform IMR of results from team meeting." Minutes of the 7/17/14 meeting added, "the team met and that fluids thickened to pudding consistency was tried by HT and will allow this to continue. Otherwise NPO." • Minutes of the 7/15/14 meeting regarding Individual #636 reported an action to discuss with the unit a hospital request for sitter. Minutes of the 7/16/14 meeting reported a sitter was in place. Regarding follow-up on systemic issues, items were kept open until resolved. The minutes identified the date an issue was first discussed. Again, the format did not clarify which information was updated, so it was often not possible to determine whether further discussion had occurred. Nonetheless, follow-up action was documented. For example: • The minutes of the meeting of 7/7/14 reported on: 7/1 Medications—inconsistency in medications at the hospital; nurse liaisons are following up with every admission to ensure the medications are correct. The meeting of 7/15/14 reported there were still issues, and notified physician. This was reported in minutes of discussion of Individual #498 at least since 7/7/14 (and possibly in minutes back to 7/1/14, as that was the date systemic review was initiated) or even earlier. The documentation of this initially as an individual issue, and then as a systemic issue, may indicate that discussion regarding one individual led to review of a systemic issue. This is a positive finding and could indicate that thorough discussion of concerns about one individual may lead to identification of systemic improvements that could improve healthcare for others. • The minutes of the meeting of 7/7/14 also reported: 7/2 Seizure meds/ taper/break through seizures. Minutes documented discussion that it was easier when seizure info was kept in chart and not in all about me book. Minutes of the meeting of 7/15/14 reported seizure records will be moved, and the item was closed. • The minutes of the meeting of 7/7/14 also reported: 7/3 Treatment was delayed if individuals did not show up for clinics. Individuals scheduled for clinics had an action taken ("Call apartment once if they do not who call unit office if they still do not show call Ken H.") and assignment of "Ken/Nancy" as responsible. Minutes of the meeting of 7/15/14 reported PCPs noted improvement and will close this item. No data were presented, and the Monitoring Team suggests data	

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		would help to ensure perceptions of improvement were accurate, and might ensure appropriate decisions are being made; nonetheless, minutes provided documentation that follow up, including at least some review of effectiveness of actions, was done. Some systemic issues were discussed and closed at same meeting. For example, minutes of the 7/15/14 discussion about UTI reported increase of E. Coli in urine recently, that hygiene training needs to be provided for difficult individuals, and this would be referred to PNMC. It was closed as an issue for further IMR review. The Facility had established a process to audit the IMR meetings. The Facility reported the HSCC audited one meeting per month and followed up on documentation. The Facility actually provided two IMR audits for May 2014 and two for June 2014. Items audited included several expectations each for the provider on-call report, the infirmary report, and the hospital report, and an item to check whether scheduled departmental/discipline reports occurred as scheduled. For the on-call, infirmary, and hospital reports, the audit records the number of individuals for which each item was done and the total number of individuals for whom it should be done, and a percentage is calculated. For the four audits provided, four items consistently achieved 100%, including: • In the on-call report, whether subjective information was present for each individual requiring intervention. • In the infirmary report, whether diagnosis/presenting problem was present for each individual and whether follow up occurred for each issue indicated. • In the hospital report, whether follow up occurred for each issue indicated. Items found less than 50% on at least one of the audits included: • At least one differential diagnosis present for each individual requiring intervention. This was consistent with the findings from the Monitoring Team review of IMR minutes. • An attending PCP plan noted for each individual with significant changes in subjective/objective information. The Monitoring Team review of IMR minutes found PCP plans to be provided for most, but not all, individuals. • Others participate in discussion of comments/plans. The Monitoring Team observed participation in discussion occurred frequently at two meetings but did not determine what percentage of individuals such discussion occurred for. • Objective information present for each individual requiring intervention. The Monitoring Team review of IMR minutes found objective information frequently but not always provided.	

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		The Monitoring Team commends the Facility on the significant change in IMR process that has occurred, and for the detailed audits that provide information to help maintain this change. The meeting has changed from a way to report a large amount of information into an opportunity for integrated discussion and decision-making, and a means to track follow-up to assigned actions. The Monitoring Team suggests the Facility consider revising the format of minutes to identify what information was actually discussed at the meeting while retaining the information about past discussions. <u>Integrated Committees and Workgroups</u> The Facility had several committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues, including, among others, the following: • As reported in Provision M6, the Medication Variance Committee was comprised of the Pharmacy Director (Chair), Medical Director, Facility Director CNE, NOO, Director of Quality Assurance, Health Service Compliance Coordinator, Center Director, and Residential Services Director. The committee consistently met monthly. The meetings followed an established agenda and were conducted efficiently and effectively. • As reported in Section O, the Facility Physical and Nutritional Management Committee (PNMC) did have a sustainable system fully implemented for resolution of systemic issues/concerns; this committee, although it did address PNM concerns, actually had evolved into a broader role. Per review of the PNMC minutes from 12/1/2014 to 5/31/2014 there was evidence that the PNMC reviewed systemic issues at DSSLC. The PNMC met at least monthly. Membership of the PNMC included the Facility Director, the Assistant Director of Programs, the Medical Director, the Chief Nurse Executive, the Director of Habilitation Therapies, the Nurse Operations Officer, the PNMT Occupational Therapist, and the Director of Quality Assurance. The purpose of the PNMC was to Identify systemic PNM and clinical issues, and develop effective action plans to address those issues, through: o Review of facility data related to PNM. o Reports from PNMT, IMRT, QA/QI, Medical, Dental, and nursing committees. o Monitoring and review of data to determine effectiveness of action plans. • As reported in Provision N8, The Facility updated its DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 04.01.04 on 2/26/2014, and upon review, the Monitoring Team noted that the Facility had followed its policy for its tracking, trending, and reporting on medication variances. The Facility's medical director, pharmacy director, and nursing director, in addition	

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		to other disciplines, including the director of residential services and director of quality assurance, all participate at the monthly medication review committee, and document their respective department's medication variance issues on the medication variance committee meeting minutes, including remediation action, and necessary system improvement initiatives. • The Facility established a workgroup to address mortalities. This group, that includes representatives from Medical Services, nursing, habilitation, residential services, quality assurance, and, as needed behavioral services and pharmacy, had developed and implemented a Mortality Action Plan that addressed a wide range of issues. <u>Integrated Planning and Services for Individuals</u> 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, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. • Based on Facility reports of attendance at ISP annual planning meetings, attendance of most disciplines was greater than 80% of meetings with many attending more than 90% of meetings. Because the ISP Preparation meeting process was inconsistent, the Monitoring Team could not determine whether attendance when required differed from the overall data provided. • As reported in Provision I1, since the last review, the Facility had initiated a process whereby every change in status (CoS) of an Individual is noted in the Facility's daily IMRT meeting and tracked in IMRT minutes. This was done so there would be a central repository of change of status data including the reason (i.e. return from the hospital), date of change, and date the five day IDT review was done. The Facility reported this process had improved interdisciplinary discussion of change of status and the timeliness of completing the five day COS review. The CoS and post hospital planning was facilitated by daily updates and follow-up by the RN Case Manager Supervisor with the RN Case Managers regarding IDT meetings and content discussed. The RN Case Manager Supervisor in Coordination with the QIDP Coordinator actively reviewed the CoS plans for quality. • As reported in Provision M1, a Physical Therapist was in the process of being teamed up with the Skin Integrity Nurse to assist with pressure wound assessments and the development of integrated plans of care. The Physical Therapist will also be able to attend individuals' appointments to the comprehensive wound care clinic when indicated. This will be of great help with positioning and prevention. The Physical Therapist will be able to do some skin	

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		debridement on campus. The long-term goal was to create a wound care team at the Facility that would include all relevant disciplines. Combining relevant disciplines will provide a more comprehensive review and management of skin integrity issues and pressure wound care. • As reported in Provision M2, to promote enhanced communication and integration, the RN Case Managers' offices were physically located in close proximity with other relevant disciplines, i.e., Qualified Intellectual Disability Professionals (QIDP), psychologist, and behavioral analyst. • In May 2014, a new process was started with the RN Case Managers conducting quarterly reviews with their respective medical providers and other relevant team members, as indicated. It was reported that this process was working well by both the RN Case Managers and medical providers, which had resulted in more thorough and comprehensive quarterly reviews for both disciplines. • As reported in Section J, the Facility had many places in the clinical process where psychiatrists, psychologists, and other IDT members worked side-by-side in settings that promoted integration of care. These included psychiatric medication review (PMR) clinics that were the place where many of the day-to-day psychiatric functions took place. At these clinics, the Psychiatrist, Psychologist, QIDP, Nurse Case Manager, and Direct Support Professional (DSP), and, at times, legally authorized representatives (LARs) and others also participated. There were numerous examples of interdisciplinary planning and integration of clinical services for individuals. For example: • The Comprehensive Psychiatric Evaluation for Individual #744 was signed by the psychiatrist, BCBA, QIDP, RN Case Manager, and 2 DSPs, indicating review by several disciplines. • Three of four (75%) acute care plans (ACPs) were integrated with other relevant disciplines, i.e., Habilitation/PNMPs and Repositioning Schedules posted by Physical Therapists. • Six of the eight (75%) individuals' integrated health care plans (IHCPs) showed adequate integration among all appropriate disciplines. • As reported in Provision R2, the Facility reported Positive Behavior Support Plans (PBSPs) are not approved without documentation of collaboration between speech and language pathologists (SLPs) and behavioral services staff. For individuals' records (Sample R.3) reviewed, the following was noted: o Four of four 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.	

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		○ For four of four individuals (100%) communication strategies identified in the assessment were included in the PBSP. ○ For four of four individuals (100%) communication strategies identified in the assessment were included in the ISP. ○ As reported in Section F, attendance at ISPA meetings did not generally include a wide range of IDT members. Although these examples demonstrate that integrated planning and integration of services occur, they also indicate that improvement was needed, as percentages of integration for ACPs and IHCPs indicated integration still did not consistently occur. There were also examples that demonstrated the need for further improvement. For example: • As reported in Provision K5, 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. • All members of the IDT were present at the CoS meeting for Individual #684. However, as reported in more detail in Provision O2, the IDT did not use the information provided to make reasonable changes in risk level ratings. The Active Record was not available and IDT was unable to clearly answer questions regarding past review or past diagnostics. There was lack of pharmaceutical review to determine if side effects of medication could result in increased mouthing or hunger. <u>Conclusion</u> As noted in past compliance reports, collaboration and integrated planning continued to improve. Improvement in the format and participation in the Integrated Morning Report shows promise of establishing integrated planning as routine, as well as providing an excellent venue for integrated discussion and identification of issues needing collaborative planning. As reported before, the numerous interdisciplinary committees and workgroups provided means to address both systemic and individual issues in an integrated manner. The commitment to integrated planning at a systemic level was made evident by the participation of the Facility Director in PNMC. There were examples of excellent integrated planning for individuals, but also other examples in which this needed improvement. The Facility is approaching substantial compliance with the provision.	

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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> There had been no revision to DADS or Facility policy governing consultations. 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. DSSLC Policy MED-01 Medical Care includes requirements for consultations. <u>Procedures and Forms</u> 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. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of nine medical consultation reports for six individuals (Individuals #18, #32, #88, #368, #731, and #744), and Modified Barium Swallow Studies (MBSS) for six Individuals #82, #312, #351, #551, #590, and #749 • For the medical consultations: o Eight of nine (89%) had evidence of review by a PCP. ▪ Eight of nine (89%) had evidence on the consultation form of review by a PCP (initials and date). Six (67%) had a progress note in the Integrated Progress Note (IPN) section of the Active Record. Of those six, the IPNs were completed within five business days for five (56% of total). One (Individual #18 cardiology consultation) did not have any documentation of PCP review. ▪ Eight (89%) documented acceptance of the recommendations either on the form or in an IPN. • For the MBSS consultations: o Six of six (100%) documented review with a note on the consultation report and/or progress note in the IPN. Six (100%) had IPNs; of those, six (100% of total) were completed within five business days. o Six of six (100%) documented acceptance or rejection of the recommendations. For Individual #82, documentation showed the clinician rejected the recommendations and provided a rationale or alternative plan. • Overall: o Fourteen of 15 (93%) documented review by a Facility clinician,	Substantial Compliance

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		through either a notation on the consultation report or an IPN, or both. o Fourteen of 15 (93%) documented acceptance of recommendations or rejection with a rationale or alternative plan. One of the sampled consultations was found to have a referral to the IDT. Although only one consultation documentation indicated a referral to the IDT, the Facility had an appropriate process in place to facilitate documentation of review of recommendations from non-facility clinicians through the IMR, and to make referrals to the IDT when appropriate. Both review of IMR meetings and of minutes of meetings verified that discussion of recommendations occurred, referrals were made to the IDT for some referrals, and follow up by IDTs was documented. The Facility provided the following documents for a consultation for Individual #551: • Consultation Report for consultation of 4/25/14 • Integrated Progress Note (IPN) of 4/28/14 by PCP • Personal Support Plan (PSP) Addendum of 5/13/14 These documents provided an example in which a consultation was followed by the IPN and by IDT review and action. Review of other cases found an example in which a recommendation from a consultant was not followed, but the Facility PCP did not provide a rationale. For Individual #719, the treating neurologist made recommendations on 12/13/2012 to discontinue Geodon; however, there was not clinical rationale documented by the assigned primary care physician for not discontinuing Geodon or considering an alternative therapy. <u>Audits of Consultations</u> The Facility conducted HSCC audits of consultations and provided data from those audits. The Facility provided a graph of HSCC audit findings for G2 from July through June (evidently 2013 through 2014, but not stated on the graph) and a graph by PCP for April, May, and June. Monthly percentages from January through June ranged from 78.6% to 100%. The graph by PCP indicated all noncompliance findings for April and May were attributable to one PCP, with consultation documents for all others being found entirely compliant. The Self-Assessment reported HSCC audit data for January 2014 through May 2014 regarding presence of required elements of medical and therapy response to consults was noted to be at 87%, consistent with an average of the monthly data. The external and internal medical audits included two questions related to review of consultations from external providers. For the Round 9 audits, all reviewed records (100%) were found to meet the requirements of those two questions (one regarding	

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		whether consultations are addressed in IPNs within five days, and the other regarding whether there is a clear rationale in the IPN if the consultant's recommendations are not implemented). Because documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and observations of Integrated Morning Report meetings and review of minutes documented examples of follow up with IDTs, this provision is found to be in substantial compliance.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. Presentation Book for Section H 4. Provision Action Information for Section H 5. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 6. DSSLC Policy CMGMT 03 Integration of Clinical Services 6/21/14 7. PNMC Clinical Indicators Actions and Results Review January 2014-July 2014 8. Quality Assurance/Quality Improvement (QA/QI) Council data reports of April, May, and June 2014 9. Quarterly data report for Sections G/H and Timeliness of Assessments of 4/29/14 with data through March 2014 10. Physical and Nutritional Management Committee (PNMC) meeting minutes 12/1/13 to 5/31/14, 6/5/14, and 7/3/14 11. Minutes of Integrated Morning Report (IMR) meetings for 6/2/14-6/6/14, 7/7/14-7/11/14, and 7/14/14-7/18/14 12. Section F Self-Assessment: Tracking spreadsheet for assessments due 12/01/2013 through 06/01/2014 13. Tables and graphs of timeliness of assessments by unit and discipline April 2013 through April 2014 14. Residential Services Management Team (RSMT) Report (undated, data through May 2014) 15. Oropharyngeal dysphagia clinical pathway 16. Description of Functional Decline Index **People Interviewed:** 1. Nancy Condon, Facility Director, Stanley Call M.D., Director of Medical Services, and Dianne Tompkins, Health Status Compliance Coordinator (HSCC) **Meetings Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #638 2. ISP Preparation Meeting for Individual #235 3. Change of Status meeting for Individuals #671 and #684 4. Physical and Nutritional Management Committee 7/24/14 5. Integrated Morning Report 7/23/14 and 7/24/14
	Facility Self-Assessment: 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. For Section H, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the

	monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ Assessment of Assessments for annual Medical Assessments ▪ Assessment of Assessments for comprehensive annual nursing assessments ▪ Quality Assurance reviews of Psychological Assessments ▪ OT/PT Assessment audits ▪ Section I At Risk Individuals monitoring tool ▪ HSCC audits regarding presence of required Section H elements ▪ External Medical Quality Assurance audits ▪ Internal Medical Quality Assurance audits ▪ Comprehensive Psychiatric Evaluation (CPE) audit tool ▪ Integrated ISP audit tool ○ These monitoring/audit tools reviewed by the Monitoring Team included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. These monitoring/audit tools generally included adequate indicators to allow the Facility to determine compliance with many of the requirements of the Settlement Agreement. Note that the Section L report identifies concerns with the extent of content of the external and internal medical audits. 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 document reviews and observations of meetings. ○ 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 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. ○ The following staff/positions were responsible for completing the audit tools: the HSCC and relevant external consultants and clinical staff. ○ 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). ○ Adequate inter-rater reliability between the various Facility and external staff responsible for the completion of the tools was not reported. The Facility reported reliability during the visit, so this would have been available. It would be appropriate for the Facility to consider it when assessing its status and to comment that this was done. ▪ Used other relevant data sources and/or key indicators/outcome measures, including: ○ Timeliness of assessments ○ Percent of newly admitted individuals who were referred to psychiatry clinic who received psychiatric assessments timely following Appendix B format

	○ Number of referrals to psychiatric services for change in status (CoS) ○ Trending data presented at QA/QI Council or PNMC, including ▪ Respiratory Infections and Pneumonias ▪ Hospitalizations ▪ Skin Breakdown ▪ All Infections ▪ Conjunctivitis ▪ Falls ▪ Deaths ○ Number and percent of Progress Notes sampled that were completed ▪ The Facility consistently presented some, but not all, data in a meaningful/useful way. Specifically, the Facility's Self Assessment: ○ Generally presented findings based on specific, measurable indicators. However, for some items of "trended outcome data," the Self-assessment summarized the trends but did not provide data. ○ 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. ▪ The Facility rated itself as being in compliance with the following provisions of Section H: Provision H2. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Completed or In Process ▪ The Facility data identified areas of need/improvement. Some areas the Facility identified were addressed, at least in part, by actions. For example, the need to improve timeliness of assessments was addressed by an ongoing review of timeliness data during quarterly QA/QI meetings; there were no other actions to improve timeliness listed. Other needs were not addressed. For example, the Facility identified a need to improve timeliness of clinical actions but did not identify actions to achieve that. ▪ 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: The Facility continued to take action to improve timeliness and use of assessments and clinical indicators. Improvement continued in some areas, such as comprehensiveness of assessments and systemic review of clinical indicators. Other areas showed less improvement, such as use of information from assessments and from clinical indicators. The Facility established or enhanced processes, such as the Change of Status

	meetings and the RSMT report; these should facilitate progress toward compliance. **Provision H1:** Timeliness of assessments continued to be high overall but variable across departments, according to Facility data. Review by the Monitoring Team found a slight decline in timeliness since the last compliance review. Use of assessment data to make decisions on treatments, supports, and services was variable. **Provision H2:** This provision came into substantial compliance. Diagnoses were consistent with current classification systems and clinically fit assessments and evaluations. **Provision H3:** Although improvement remains needed in both timeliness of treatment and in clinical appropriateness, the improvement in both since the last compliance visit is significant. Both timeliness and clinical appropriateness are now routine findings but enough exceptions occur so that a finding of noncompliance remains. **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. 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 a limited set of targeted measures that could lead to proactive treatment decisions prior to such instances and, at the same time, indicate trends in health status facility-wide. **Provision H5:** There has been improvement in identifying data to be monitored, but further improvement needs to be made in implementing monitoring as planned and in reviewing and evaluating the information each month. **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 were tracked, but they were not reviewed and assessed for need for revision of treatment or did not result in revisions. The regular use of the CoS system and the QIDP monthly review should improve timeliness of program revision in response to clinical indicators. This will only happen, though, if the IDT and the QIDP analyze data and other clinical indicator information accurately and thoroughly and take action, which is not yet occurring consistently. **Provision H7:** Although policies have continued to be developed and to evolve, implementation still must improve in order to find substantial compliance.

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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.	Policy 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. DSSLC Policy CMGMT 03 Integration of Clinical Services requires clinicians to "perform assessments or evaluations on a scheduled basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs." It requires completion of an initial assessment to permit development of and ISP within 30 days of admission. The policy lists the clinical assessments that will be completed on a scheduled basis "prior to the Individual Support Plan" or as otherwise noted, and it requires all clinical departments to monitor for timeliness of scheduled assessments an appropriateness of assessments in response to a change in status. Extent to which assessments are conducted routinely In its Self-assessment, the Facility provided monthly data on medical, OT/PT, Speech, nursing, dental, and psychiatry assessments (but not behavioral assessments) for each month from January 2014 through May 2014. These showed timeliness ranging from 79% to 100%. The range is similar to that from the last Self-assessment (which was 71% to 100%) but includes fewer disciplines and assessments than the 10 reported at that time. The Facility provided tables and graphs of assessment timeliness by discipline/assessment and unit from April 2013 through April 2014. Data from January 2014 (the month of the last compliance visit) through April 2014 showed monthly ranges by discipline or assessment from 53% to 100%. Monthly ranges by unit were from 68% to 90%. Certain disciplines showed stable and relatively high percentages of timeliness (such as Life Skills, Vocational, Speech, and Pharmacy), but most showed lower or more variable timeliness. Overall for the Facility, timeliness showed a small downward trend for the period displayed. A separate timeliness of assessment data table provided during the visit included data for June 2014; the data seemed mostly quite consistent with the information through May 2014. The Facility also provided the RSMT Report with data through May 2014. This report had been implemented since the last compliance visit. The report included a variety of information on issues relevant to the responsibilities of residential management staff. One set of information was on timeliness of functional skills assessments (FSAs), for which there was a graph of campus wide timeliness (for October 2013 through May	Noncompliance

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		2014) and one for each apartment. The date range for the apartments were unclear, because months with 0% timeliness at the beginning or end might have been months for which this was not reviewed (either because the process had not begun or because there was no ISP planning meeting for any individual during that month), and because some graphs showed data only for a reduced range of months (for example, Houston Park 513B graph only covered November 2013 through March 2014, and the graph for Pine Ridge 505A only showed March and April 2014). Residential management staff would know whether there were ISP meetings during a month, but that would not be clear to any outside reviewer. The Monitoring Team reviewed this with the assumption that a 0% data point meant that no FSAs were timely but with an understanding that there might be few or no FSAs due in a specific apartment for a given month. Based on the data in these graphs, there was a decline in timeliness campus-wide from October 2013 through May 2014. Data were extremely variable across apartments and units. The lack of data points made it impossible to gain a clear picture of timeliness by apartment, but those in the Houston Park unit seemed generally timely, whereas there was more variability in the remaining units. This information should be helpful to residential managers so they can identify where lack of timeliness needs to be addressed. Furthermore, information reported in Provision F1c substantiated that assessments required to develop an appropriate ISP meeting were still not consistently 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. In a sample of eight ISPs completed prior to the monitoring visit, none (0%) had all required assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. In several instances, some assessments were still not completed until after the meeting was held. Overall for this sample, the rate of timeliness was 68%. Additional information in this report indicated timeliness of routine assessments varied across disciplines, which supports the findings above: • As reported in Provision K5, DSSLC had made only slight progress in ensuring that Psychological Evaluation reports were completed in a timely manner. Although some progress was noted in intellectual assessments, a substantial decline was noted in the provision of timely adaptive skill assessments. Only three of 10 individuals (30%) had been provided with a current adaptive skill assessment. Sixty-eight of 460 individuals (15%) were not reported to have a psychological assessment report in the previous year. • Three of 15 recently admitted individuals (20%) were provided with adaptive skill assessments within 30 days of admission. • Seven of 15 recently admitted individuals (47%) were provided with intellectual assessments within 30 days of admission.	

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		• Eleven of 15 recently admitted individuals (73%) were provided with behavior assessments within 30 days of admission. • Fourteen of 15 recently admitted individuals (93%) were provided with psychological assessment reports within 30 days of admission. • As reported in Provision M2: • Three of three (100%) Admission Nursing Assessments were completed timely, within 30 days of admission. • Seven of eight (88%) Annual Comprehensive Nursing Assessments were completed timely, within 10 days of the ISP meetings. • One of one (100%) Quarterly Nursing Assessment was completed by the last day of the month that the quarterly was due. • As reported in Provision P1, seventeen of 17 individuals (100%) admitted since the last review received a comprehensive OT/PT assessment within 30 days of admission and 5 business days of the ISP. 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. Fifteen of 15 individuals' OT/PT assessments reviewed (100%) were dated as having been completed at least 10 business days prior to the annual ISP. • As reported in Provision Q1, the most recent annual dental summary was completed prior to the annual ISP meeting, in five out of five (100%) examples. • As reported in Provision R2, eight of eight individuals in the sample reviewed (100%) were provided a communication assessment per policy and/or Master Plan. All individuals in the sample received assessments annually if the individual was provided with direct or indirect services. Eight of eight individuals in the sample (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP planning meeting. Seventeen of 17 individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission and five business days prior to the ISP. <u>Comprehensiveness of Scheduled Assessments</u> 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: • 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.	

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		• DSSLC had also developed an assessment of assessments for the FSA summary completed by the QIDP and completed random audit for one Functional Skills Assessment/Summary per QIDP per quarter to ensure adequate evaluation of the individual's functional skill level. • As reported in Provision J6, the Facility had focused its efforts in improving psychiatric assessments on the comprehensive psychiatric evaluations (CPEs). Review by the Monitoring Team found that the quality of the evaluations continues to improve, particularly in the area of diagnostic justification. The effort to bring the quality of the psychiatric evaluations to the required standards was nearing its goals, but some work remains. • As reported in Provision K5, substantial improvements had been made in behavioral assessments. The lack of intellectual and adaptive assessments limited the comprehensiveness of psychological assessments. • As reported in Provision L1, the Facility must ensure that periodic clinical assessments for individuals with chronic health conditions are done, including physical assessments and review of diagnostics and clinical data. • As reported in Provision P1, most required components of OT/PT assessments were completed, but there was a lack of identification of a schedule for monitoring. All areas were noted to have continued improvement with the exception of the identification of the monitoring schedule. • As reported in Provision Q1, annual dental assessments included many essential components but need to provide a summary of oral health care issues. • As reported in Provision R2, communication assessments were substantially comprehensive. Although some components in the sampled assessments were not consistently included, more recent assessments included essential components. <u>Assessments in Response to a Change of Status</u> 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. As reported in Provision J7, there were two referrals to psychiatric services due to possible change of status for individuals not receiving psychiatric treatment; for both, psychiatric evaluation was completed. The protocol was not followed for Individual #218, who was referred to psychiatry without having had a Reiss screen first. As reported in Provision L1 regarding acute medical conditions, the medical provider usually documented physical assessment. However, periodic assessment to ensure the	

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		individual responded to treatments was not done as consistently. As reported in Provision O2, assessments or reviews for individuals referred to the Physical and Nutritional Management Team (PNMT) were consistently initiated timely. Reviews were comprehensive. Only one initial assessment led to a full assessment, which was completed timely and was comprehensive. <u>Use of Information from Assessments</u> Examples were found both of use of information from assessments and of lack of use of the information. • As reported in Section O, PNMT assessments were important in planning services and supports. However, recommendations by the PNMT were not addressed in ISP addendums (ISPAs) or Integrated Health Care Plans (IHCPs). It should be noted that a Corrective Action Plan was developed as of 12/4/13 to address integration of PNMT recommendations but positive outcomes of the CAP have not been noted. • As reported in Provision S1, it was not always clear that information from assessments was considered when establishing specific skill acquisition objectives. Functional Skill Assessments (FSAs) for only four of 10 SAPs (40%) reflected evidence to support the reviewed SAP. • As reported in Provision F1d, 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. There was some progress noted in this regard. For example, as reported in Provision P2, skill acquisition programs were now recommended in the OT/PT assessments.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Medical diagnoses were consistent with the ICD classification system. There was one area in which improvement was needed. Seizure disorder was occasionally diagnosed without further specification. For example, the active problem list might indicate seizure disorder but would not provide a more specific diagnosis that would better describe the type of seizure disorder. For psychiatric documentation reviewed, in each case the documents included 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 most current psychiatric evaluations.	Substantial Compliance

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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.	Timeliness of Implementation The Self-assessment included reports of data on timeliness for: • PBSPs/IBHA programs: 83% were implemented within 14 days of obtaining consents, and 76% were implemented within the required timeframe., with an average time from date of assessment to implementation of 47 days. Two separate numbers were given for total number of programs. • At-Risk action plans: 78.9% were implemented within 14 business days The Self-assessment also reported on results of external and internal medical audits: significant abnormal diagnostic test results were addressed timely for 100% of sample for the eternal audit and 86% of the sample for the May 2014 internal audit. Timeliness of implementation continued to improve or be maintained in many areas but remained variable. Examples of improvement included: • For individuals determined at risk, plans were implemented within 14 days of finalization in 80% of cases sampled. This is almost identical to the figure provided in the Self-assessment. When the risk to the individual warranted (eight cases), the Facility took immediate action in each (100%). • As reported in Provision Q1, when identifying a need for restorative treatment, the Facility provides restorative treatment without prolonged delay. • Timeliness of Human Rights Committee psychotropic medication reviews (with 100% of those sampled reviewed in a timely manner) permitted timely initiation of new psychotropic medications. • As reported in Provision M3, acute care plans (ACPs) continued to be implemented upon diagnosis of pressure wounds. Furthermore, ACPs were consistently initiated within 12 hours of diagnosis of a urinary tract infection, and were initiated within 12 hours of the diagnosis of the Reportable Infectious/Communicable Disease in two of three (67%) sampled cases. • As reported in Provision P2, OT/PT supports and services were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety need. • As reported in Provision K9, review of Facility tracking data reflected that the Facility had demonstrated considerable improvement in implementing IBHA/PBSPs promptly after approval and consent were obtained. Examples indicating a need for improvement included: • As reported in Provision K4, progress noted for a sample of behavior intervention programs reflected several cases of lack of progress or worsening behavior without a timely response. For example: • Progress notes for three of 10 behavior intervention programs (30%) were	Noncompliance

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		noted to reflect worsening behavior or other problems without a timely response from the program author or IDT. • Furthermore, 70% of the sample programs reviewed showed that either progress was evident, or the program was modified after three months. This compared to 64% during the last compliance review period. • As reported in Provision Q1, there were delays in providing prompt treatment of dental care for dental emergencies. • As reported in Provision O2, for zero of four (0%) plans developed by the PNMT that the Monitoring Team reviewed, supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. <u>Clinical Appropriateness</u> The Self-assessment included reports from: • External and internal medical QA audits. External audits found proper management of diabetes at an average score of 94.5%, and proper management of osteoporosis at 79%. Internal audits found proper management of diabetes at 100% and of osteoporosis of 100% in May 2014. • Integrated ISP audits reported: o IDT discussed clinically appropriate treatments and interventions at 72.7%. o IHCPs for all risks were developed during 78.2% of meetings 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. • As reported in Provision P2, the ISP or ISPA consistently described the supports based on the rationale provided in the therapy assessment. • As reported in Provision K9, there had been significant improvement in providing rationales for selection of proposed IBHA/PBSP interventions. This was likely due, in part, to improvements in behavioral assessments, as reported in Provision K5. • As reported in Provision J3 for Individuals #230 and #132, information in psychiatric support plans (PSPs) either supported or explicitly stated there was a need for a PBSP, but PBSPs were not in place for those individuals. • As reported in Provision L1: o Provision L1 reported that medical providers did not regularly assess efficacy of prescribed supports and services for recurrent pneumonia. Therefore, it could not be clear that treatment and interventions remained appropriate. This was the case, for example, for Individuals	

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		#66 and #499. Although improvement remains needed in both timeliness of treatment and in clinical appropriateness, the improvement in both since the last compliance visit is significant. Both timeliness and clinical appropriateness are now routine findings but enough exceptions occur (as noted in both the Monitoring Team's findings and in data provided by the Facility) so that a finding of noncompliance remains. The Facility must ensure that clinicians address cases in which the data and clinical information indicate there is no improvement or there is worsening of the individual's status.	
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> 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: • 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." • Clinical indicators will assess quality of care structures such as staffing of the infirmary, processes that constitute health care, and outcomes that follow care. The policy provides examples of each. • 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(.)" <u>Use of Clinical Indicators for Individual Care and Treatment Decisions</u> The Facility reported that there is a list of clinical indicators that medical care providers should be reviewing. There was not indication that data or other information from these indicators is regularly aggregated or reviewed, or that tracking of specific indicators was required for specific health care conditions. The Facility reported there had been additional development of indicators and use of indicators for chronic care quarterly reviews. These included: • Weight report, significant weight gain or loss • Multiple pneumonias • Daily report of individuals who have fall three times in a month • Updated cardiac clinical indicators • Revised preventive care flowsheet The Facility reported that clinical pathways for 11 diagnoses have been developed. The	Noncompliance

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		Monitoring Team did not review the clinical pathways but understands that clinical indicators, both in the form of information and data, are included. The Facility did not indicate how those data are tracked or what actions result from audit findings. The graph of HSCC audit findings for this provision showed data on "Monthly Overall Averages," so the Monitoring Team could not assess whether this address use of clinical pathways in chronic care. This will be important information needed to assess compliance as the Facility continues to improve medical services. The Monitoring Team did identify examples of use of clinical indicators for individual care and treatment: • As reported in Provision M5, five of the eight (63%) individuals' IHCPs identified appropriate clinical indicators to be monitored and the frequency. • As reported in Provision R3, for records reviewed of individuals received direct speech intervention, there were measurable objectives related to individual functional communication outcomes included in the ISP. The Monitoring Team also identified examples in which it was not clear that clinical indicators had been established and were used for making decisions: • As reported in Provision R3, for individual receiving indirect speech Services, quarterly documentation did not consistently contain information regarding whether the individual showed progress with the stated goal(s) or objectives. • As reported in Provision L1, there was not evidence that medical providers periodically reviewed, outside the annual medical assessment, blood pressure results and monitoring labs, and physical assessment. <u>Use of Clinical Indicators for Systemic Improvement</u> Clinical indicators were included in reviews by the PNMC, the QA/QI Council, and Integrated Morning Report (IMR). The set of data reviewed by these committees primarily involved adverse outcomes, such as infections, illnesses, and hospitalizations. Review by PNMC: 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. The Facility provided a PNMC Clinical Indicators Actions and Results Review January 2014-June 2014. This report included monthly graphs of a wide range of indicators, such as: • All pneumonias diagnosed • Aspiration pneumonias diagnosed • Hospitalizations • Decubitus	

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		• Upper Respiratory Infections (URI) • Conjunctivitis • MDRO infections • Urinary Tract infections (UTI) • Deaths • Slips/trips/falls The report also included, for each area addressed (such as pneumonia) a table that listed the reasons for actions, the actions, the month/year for each action, and the status/results. Actions were listed chronologically. Many of the actions described processes in decision-making, such as (under Pneumonias) reviewing an analysis and pulmonologist recommendations to see if additional actions are needed. Others described actions taken, such as "Developed flowsheet for pneumonias" and "Dexa scan is installed which should lessen sedations and risk of aspiration associated with sedation(.)" In this section, the table documented monthly review of pneumonia data and decisions about actions based on those data. Monthly or bi-monthly review was also documented for URIs, decubitus, conjunctivitis, infections, and deaths. QA/QI Council Review of Trends in Clinical Indicators: Section Leads reported quarterly on each section. In many cases, most of the information provided related to compliance on monitoring or audit tools, including percentages of required components documentation as measured in audits. 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. Clinical indicators reviewed during the QA/QI Council meetings of April, May, and June 2014included: • Number of hospitalizations • Number of deaths • Number of all infections • Number of all pneumonias • Number of aspiration pneumonia infections • Number of uses of STAT medications other than for constipation and number of uses for constipation • Number of individuals with metabolic syndrome diagnosis • Number of potential ADR (adverse drug reaction) reports • Number of restraints • Oral hygiene ratings Audit reports generally reported "Overall Average." They did report the number of	

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		audits done. They also reported the percentage for the prior quarter by audit question and indicated which questions were below the standard for compliance and, for some, explanations or actions taken. For a number of topics, audit information was provided but not information on status of health care conditions. For example, in the April 29, 2014 report, the percent of compliance on documentation of urinary tract infections (UTIs) was reported, but data on numbers of UTIs was not reported. This was true also for hospitalizations, but number of hospitalizations was reported in the June 2014 report. 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. The Facility should identify what data will provide a clear picture of whether health care is or is not improving. For example, data were provided from audits of status epilepticus but the number of incidents was not provided, nor was information on how many cases required hospitalization or movement to the infirmary. To identify when there is a need to develop proactive strategies, or to correct conditions that might affect the incidence and prevalence of a health condition, the Facility needs to look at more than the quality of documentation when the health condition occurs. It should be noted that some data on incidence were provided at PNMC meetings, such as data on decubitus through February 2014 in the PNMC minutes of the 5/15/14 meeting. 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 a limited set of targeted 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. Some clinical indicator graphs did not provide adequate information to be useful or did not indicate the information was evaluated accurately. For example: • 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. Furthermore, the graph clearly showed a decrease in ratings of Good and small increases each in Fair and Poor (with decreases in poor for the last two months of the quarter). The statement below the graph was, "Improvement over the last quarter is noted." This improvement was not evident from the graph. The Monitoring Team did not review other documentation from the meeting to determine whether the	

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		QA/QI Council noted and corrected this. The Monitoring Team commends the Facility on establishing processes for reporting of clinical indicators and acting on the information. Improvements such as providing data on incidence might assist the Facility to take a proactive approach to identifying factors that could improve outcomes, in addition to assessing timeliness and quality of documentation and responses to incidence of health conditions. Review at Integrated Morning Report: 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 in the 6/3/14 minutes that reported an ADR. The minutes of the 6/4/14 meeting included a community transition report that listed the post-move monitoring observations from January 2014 through May 2014 with data on any adverse incidents such as ER/hospitalization. This process had continued since the last compliance visit and is a useful way to provide information on clinical indicators to a broader set of staff. <u>Use of clinical indicators by the Physical and Nutritional Management Team (PNMT)</u> As reported in Provision O2, the PNMT addressed clinical indicators in planning and implementing supports and services for individuals. • Four of four (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, Integrated Risk Rating Form (IRRF), PNMT minutes and ISPA. • Four of four (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. <u>Conclusion</u> 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	<u>Policy</u>	Noncompliance

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	the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	DSSLC Policy CMGMT 03 Integration of Clinical Services includes a statement that "A system to monitor the health status of the individual is the responsibility of the clinical discipline lead that will identify the appropriate level of oversight required." It also discusses the review of data by the QA/QI Council or PNMC. The involvement of the QA/QI Council or PNMC is appropriate, because health status is not always dependent on what one discipline does but instead involves the assessments, action plans, and involvement of multiple disciplines. Nonetheless, many of the health indicators are within the purview of a specific discipline. The policy should recognize that the clinical discipline lead is responsible for developing a system to monitor those health status indicators within the purview of the discipline, but the multiple disciplines of the IDT must be involved as appropriate. The Facility had revised its quarterly health review process. Since the last compliance visit, the Facility had initiated a process in which the RN Case Manager and medical provider serving an individual meet quarterly to review findings. This is to include review of medical records, the active problem list, preventive care flow sheet, the nursing quarterly health review/physical assessment, the Integrated Health Care Plan (IHCP) and any Change of Status (CoS) IHCP, the IRRF, and any CoS IRRF. Following the review, the medical provider and RN Case Manager are to document the review in the Integrate Progress Notes (IPN). The Facility had continued to use several review processes to monitor health status of individuals. As reported in Provision H4, aggregate information is reviewed in both PNMC and QA/QI Council meetings. The Self-assessment provided trended outcome data presented at QA/QI Council and PNMC. These involved hospitalizations, pneumonia and respiratory infections, skin breakdown, infections, conjunctivitis, falls, and deaths. Implementation of processes to monitor health status of individuals and to integrate clinical indicators into such monitoring remained a work in progress. The involvement of the IDT through the IRRF process and QIDP monthly reviews was not yet fully in place. • The Facility still continued to experience difficulties in the implementation of QIDP Monthly Reviews and clinician monthly reviews, but there was some improvement noted. o As reported in Provision O7, QIDP monthly reviews mostly 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. It should be noted that the above percentage represents an improvement of 24% since the last review. o As reported in Provision K4, data on progress in IBHAs/PBSPs was	

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		reviewed monthly for 0% of the sampled programs. Only 50% of the monthly reviews were done by a Board Certified Behavior Analyst. More concerning, progress notes for three of 10 behavior intervention programs (30%) were noted to reflect worsening behavior or other problems without a timely response from the program author or IDT. This indicates the QIDP did not address the worsening data, nor did the clinician. Other examples of monitoring and use or lack of use of clinical indicators included: • As reported in Provision I3 for a sample of 20 individuals, there was documentation that the Facility: o In 14 (70%), appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. This compares to the 67% compliance rate noted in the last report by the Monitoring Team. o Seven (35%) included the clinical indicators to be monitored and the frequency of monitoring. This compares to the 33% compliance rate noted in the last report by the Monitoring Team. • As reported in Provision J3, data-based monitoring of medications for efficacy was a key element of psychiatric treatment. Treatment plan information on how medications were to be tracked for efficacy was contained in 16 of 16 (100%) of the treatment plans. As reported in Provision J13, graphs with data were provided for 75% of the individuals in the sample. Some work remained to be done on the development of meaningful tracking. For example, there remained a need to link at least one of the selected targets to the underlying psychiatric diagnosis. • As reported in Provision L1 regarding monitoring of hypertension, the IRRF documented clinically relevant information for individuals with the diagnosis of hypertension, and included specific monitoring and reporting parameters, in one out of five examples (20%). There was no evidence that the medical provider periodically performed clinical assessments of the individual, outside of the annual physician's review, by reviewing average blood pressure results, necessary monitoring labs, and documenting a physical assessment in four out of five examples (80%). • As reported in Provision L1 regarding Individual #66, the Individual experienced 17 episodes of pneumonia since 2010, with three episodes occurring during this reporting period. Although there was a diagnosis listed for recurrent pneumonia, there was no plan that documented specific monitoring and reporting parameters, or necessary supports and services. There was no evidence documented by the medical provider indicating periodic evaluation of	

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		the individual for recurrent pneumonia diagnosis, and to assess efficacy of supports and services to help mitigate recurrent pneumonia. The IHCP process should provide a means for IDT tracking of indicators of status of individuals in relation to identified health risks. Although there was improvement in including these, not all IHCPs or ISPAs included the indicators to be monitored, or the monitoring was not done as planned. • Thirteen of the 13 individuals' records for Samples O.1 and O.2 (100%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. Four of the 13 individuals' records in samples reviewed (31%) 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. • Six of the eight (75%) individuals' IHCPs incorporated appropriate functional and measureable objectives into the ISP to measure the efficacy of the plans. • As reported in Provision P2 for individuals with PNMPs or SAPs, for zero of six individuals reviewed (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. The last report noted the Facility was approaching substantial compliance with this provision and needed to ensure monitoring is done regularly and documents progress or regression based on data and other information. There has been improvement in identifying data to be monitored, but further improvement needs to be made in implementing monitoring as planned and in reviewing and evaluating the information each month.	
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. Examples are provided throughout this report of modifying treatments and interventions, including: • The Change of Status (CoS) meeting process was regularly implemented. As noted in Provision I.2 in its self-assessment the Facility reported it had achieved a 97% compliance score with respect to COS meetings occurring within five days, and the Monitoring Team found this had occurred for 82% of the	Noncompliance

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		individuals in the sample reviewed. The Monitoring Team observed CoS meetings for Individuals #671 and #684. Examples in which improvement is needed included: • As reported in Provision I1, the CoS meeting for Individual #671 did not result in needed revisions to treatments and interventions. o The IDT reviewed the current IRRF but made no changes until prompted through discussion by members of the Monitoring Team. o No clinical record was available and the IDT was unable to clearly answer questions regarding past review or past diagnostics. This would have been possible if the record was present. o There were issues not noted by IDT including: ▪ Lack of identification of changes in risk levels and in addressing these with changes in interventions. For example, the IDT did not increase GI risk although objects in the past have required removal. The IDT stated that Bowel Obstruction was already high so why increase this one too. ▪ Noted no increase in behavior although PICA behavior had increased. IDT stated "why increase his risk when it is our problem that he is having increased PICA" • As reported in Provision K4, 70% of individuals with IBHAs/PBSPs in a sample reviewed by the Monitoring Team either showed improvement or had revisions in programs. Progress notes for three of 10 behavior intervention programs (30%) were noted to reflect worsening behavior or other problems without a timely response from the program author or IDT. This was similar to the percentage found in the last compliance review. The regular use of the CoS system and the QIDP monthly review should improve timeliness of program revision in response to clinical indicators. This will only happen, though, if the IDT and the QIDP analyze data and other clinical indicator information accurately and thoroughly and take action, which is not yet occurring consistently.	
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 Sections G and H together. Although this policy had been initiated in November 2010, it had not yet been completed and implemented. The Facility had revised DSSLC Policy CMGMT 03 Integration of Clinical Services, The policy addresses assessment, development and use of clinical indicators for monitoring health status of individuals. The policy does not assign responsibility for development of clinical indicators, other than to state they "will be used by QAQI, PNMC regularly and others as needed to make center-wide changes and to assess	Noncompliance

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		effectiveness of actions." The Facility might consider identifying a process for developing clinical indicators that assigns responsibility in a manner that recognizes the clinical expertise of specific disciplines while also involving other disciplines to ensure integrated planning. 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. Other policies also referenced integrated services. For example, as reported in Provision O1, a localized PNMT policy (DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy-rev 6/25/2014) 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. The Facility did have evidence of a comprehensive PNM Policy. Although policies have continued to be developed and to evolve, implementation still must improve in order to find substantial compliance.	

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. Section I Presentation Book (undated) 4. DADS Policy 006.1 At Risk Individuals (12/7/12) 5. DSSLC Policy CMGMT -14 At Risk Individuals (1/15/13) 6. DSSLC Policy CM 14- Addendum H (To State Policy) At Risk System (6/20/14) 7. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 3/3/14) 8. DSSLC Policy CMGMT 34 Occupational/Physical Therapy Services (rev 3/3/14) 9. DSSLC PNMT Process Flow Chart (10/17/13) 10. Record reviews: a. Sample O.1: Individuals #66, #167, #463, #551, #553, #743, #749, #752 and #776 b. Sample O.2: Individuals #517, #565, #576, and #590 c. Sample O.3: Individuals #5, #28, #82, #89, and #690 d. Individual #499 11. Record reviews for Individuals #312, #749, #553, #66, #590, #776, #167, #565, #279, #438, #49, #626, #692, #436, #456, #7, #671 ,#204, #766, and #373 (sample selected for data analysis) 12. Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) for Individuals #102, #167, #394, #690, #715, #251, #456, #21, #727, #626, #671, #127, and #110 13. Individual Support Plans (ISPs) for all sampled individuals 14. Completed Physical Nutritional Management Plans (PNMPs) for all sampled individuals 15. Tools used to monitor implementation of PNM procedures and plans 16. List of Top 10 individuals causing injury to peers 17. List of Top 10 injured individuals. 18. List of individuals supported with bedrails 19. List of individuals injured from bedrails **People Interviewed:** 1. Nancy Condon, Facility Director 2. Paula Horn PT- Director of Habilitation Therapies (HT) 3. Jean Mykietyn OTR, PNMT Lead 4. Stacy Krause PNMT RN 5. Six direct care professionals (DCPs) (Cedar Falls, Timberhill, and Westridge) **Meetings Attended/Observations:** 1. Physical and Nutritional Management Team (PNMT) 7/21/14 2. Change of Status Meeting—Individuals #684 (7/24/14) and #671 (7/23/14) 3. Physical and Nutritional Management Committee (PNMC) 7/24/14 4. Integrated Morning Report Meeting (IMR) 7/23/14

	5. Mealtimes and Transitions- Cedar Falls, Westridge and Timberhill 6. QA/QI Council 7/22/14 7. ISP meetings for Individuals #280 and #628 8. Incident Management Review Team (IMRT) 7/21/14 and 7/23/14 9. Quality Assurance/Quality Improvement Council (QA/QA Council) meeting 7/22/14 10. Mortality Action Plan Review Meeting 7/23/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included the standard Section I monitoring tool, the ISP monitoring tool, QA/QI reports, and various data reports. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability was established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources and/or key indicators/outcome measures, such as databases that showed trends in key clinical areas such as multiple diagnoses of aspiration pneumonia, skin breakdown, hospitalizations, and infectious diseases. ▪ Generally presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Did distinguish data collected by the QA Department versus the program/discipline.

	The Facility rated itself as in substantial compliance with Provisions I.1 and I.2 of Section I. This was not consistent with the Monitoring Team's findings. Many of the compliance scores calculated in the Facility self-assessment showed scores in the mid-80th percentile. This was not sufficient to demonstrate substantial compliance. Additionally, 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. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The Action Plan was detailed and comprehensive. It listed 28 separate ongoing activities and 27 additional action steps that had been initiated or completed since the last review. ▪ Actions were reported as complete or in process. Of the 27 action steps reported in the Action Plan 15 (56%) were reported as completed. Others were described as "in process". ▪ The Facility data identified areas of need/improvement primarily related to additional staff training, tracking of data, improved interdisciplinary collaboration, and continued implementation of the at-risk policy. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. For those Provisions determined to be in noncompliance by the Monitoring Team the Facility should examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The Monitoring Team observed steady progress in moving towards compliance with Section I of the SA, most notably in the content and attendance at the Integrated Morning Meetings and in the use of the IMRT in tracking change of status events. While some compliance scores improved from that noted in the last review others did not. Overall the Facility demonstrated improvement in its at-risk processes from that observed at the last review. The statewide risk assessment policy, with guidelines for rating risk, was in use at the Facility. The Facility also used supplementary tools that IDTs could use in the risk assessment planning process. The Facility had initiated a Facility specific policy (CM 14) addressing its At Risk system. The Facility continued to have a very active Physical and Nutritional Management Committee. It was evident to the Monitoring Team that the work of this committee was substantive and oriented to decision-making. The committee members were the key players needed to effectively implement the policies and procedures necessary to achieve compliance with this Provision of the SA.

	The Monitoring Team observed 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. 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. Most of the compliance scores reported in Provision I.2 and I.3 had not changed significantly from that reported in the last report by the Monitoring Team and remain at a level that is not sufficient to find substantial compliance.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	As was noted in 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 revised the Facility specific policy (CM 14) addressing its At Risk system. This revision more clearly articulated the various systems components in use at the Facility that are part of the at-risk system. The Facility continued to experience difficulty in consistent implementation of its risk screening, assessment and management system. As reported in Provision I.3 compliance scores calculated by the Monitoring Team continued to be, for the most part, unacceptably low and had, for the most part, showed only marginal continued improvement from that noted in the last review. In its last report the Monitoring Team noted that the Facility had made substantial progress and that many compliance scores had improved significantly. This trend of significant improvement appeared to have abated. 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). IRRF forms were not always fully completed. For example, in the behavioral health section of the IRRF the form template requires one of two choices be marked under "Consideration of the Use of Restraint." Almost without exception this did not occur. Additionally, IRRF forms did not always include important clinical information. For example, as reported in Provision L.1 for Individual #499 under the topic of aspiration, the IRRF did not document a clinically meaningful current status,	Noncompliance

#	Provision	Assessment of Status	Compliance
		and did not complete the recommendations, discussions, team deliberation, and risk rating components of the IRRF. In addition, despite the Individual having experienced many aspiration pneumonias, known aspiration risk factors, GERD, seizure disorder, recurrent emesis, and an enteric tube placement, the IRRF did not indicate that the Individual was at risk for aspiration, and documented "no history of choking in the past 3 years". The Monitoring Team is concerned that these underlying medical conditions did not lead the Facility to consider the Individual at risk for choking. The Facility continued to have a very active Physical and Nutritional Management Committee (PNMC). This group met weekly 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 Monitoring Team observed substantive interaction among and between attendees. 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. The IDT used the Risk Level Guidelines established in State policy for assessing and determining risk levels. The Monitoring Team observed two 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, although for the ISP for Individual #628 some team members were in and out of the meeting. While this did not appear to have a significant effect on this meetings content, these types of distractions might affect decision-making at future meetings. The Facility should ensure that if certain disciplines are identified as necessary participants in an ISP meeting, every effort be made to ensure their attendance for the entire meeting. In both meetings the IDT used the risk guidelines adopted by the Facility to guide its discussion. In both meetings the IDT used clinical data in reviewing risk and determining risk levels. In both meetings the ISP Facilitator was able to keep the IDTs risk discussion focused. The Facility conducts a daily IMR, that meets on regularly scheduled business days to review all on-call issues that occurred the previous night, review current hospitalizations, update on individuals in the infirmary, and discuss significant clinical issues. 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. The Monitoring Team attended the morning meeting on	

#	Provision	Assessment of Status	Compliance

		7/23/2014, and noted significant improvement in the overall functioning of the meeting, compared to previous compliance review visits. The meeting appeared well organized; the participating clinical pharmacist had computer access to clinical data, and presented real-time information on relevant clinical issues; medical providers actively participated at the meeting, and provided meaningful clinical insight for cases discussed; nursing and other professionals were observed to be equally engaged. The Monitoring Team reviewed minutes of a number of these meetings; minutes supported the observations made of this meeting.
		
		Since the last review, the Facility had initiated a process whereby every change in status (CoS) of an Individual is noted in the Facility's daily IMRT meeting and tracked in IMRT minutes. This was done so there would be a central repository of change of status data including the reason (i.e. return from the hospital), date of change, and date the five day IDT review was done. The Facility reported this process had improved interdisciplinary discussion of change of status and the timeliness of completing the five day COS review. As noted in Provision I.2 in its self-assessment the Facility reported it had achieved a 97% compliance score with respect to COS meetings occurring within five days. This was higher than the 82% reported by the Monitoring Team from its sample. In either case this was a higher compliance score than that reported in the last review indicating this new process was likely having its intended effect.
		
		The Monitoring Team observed two Change of Status meetings. For Individual #671 the IDT COS meeting did not result in any change in risk ratings. The meeting did not directly address risk but rather recent escalation in targeted behavior issues, actions the team had previously put in place, discussing what seemed to work and what didn't, and developing additional actions. The Individual's mother was an active participant in the meeting.
		
		For Individual #684 the Individuals PICA issues were the primary reason for the meeting. For this meeting:
		• The IDT reviewed the current IRRF but made no changes until prompted through discussion by members of the Monitoring Team.
		• No clinical record was available and the IDT was unable to clearly answer questions regarding past review or past diagnostics. This would have been possible if the record was present.
		• There were issues not noted by IDT including:
		  • Increased risk of aspiration pneumonia due to providing oral stimulators which would increase saliva. The Individual was known to silently aspirate on thin liquids.
		  • Increased risk of bacterial pneumonia due to no clear process in place to	

#	Provision	Assessment of Status	Compliance
		ensure projects mouthed are cleaned on a regular basis. • The IDT did not increase GI risk although objects in the past have required removal. The IDT stated that Bowel Obstruction was already high so why increase this one too. • Noted no increase in behavior although PICA behavior had increased. IDT stated "why increase his risk when it is our problem that he is having increased PICA" • Lack of review of potential GERD implications • Lack of review of pharmaceutical review to determine if side effects of medication could result in increased mouthing or hunger. From this meeting it was clear 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. In fact,, as reported in this COS meeting, this Individual had multiple incidents of PICA that were not addressed by the IDT for nearly seven months. 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: • Hospitalizations • ER visits • Deaths • Skin Integrity • Enteral Nutrition • Aspiration Pneumonia • Pneumonia • Falls • Diabetes Management Report • Individuals followed by PNMT and the PNMT's level of involvement • UTIs • Pseudomonas 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. Based on this review this Provision was not in substantial compliance.	

#	Provision	Assessment of Status	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 97% which compares to the 78% reported in its self-assessment six months earlier. This was a higher level of compliance than that reported by the Monitoring Team from its sample as noted below. The Monitoring Team selected 20 records to review to assess compliance with this provision. These were for Individuals #312, #749, #553, #66, #590, #776, #167, #565, #279, #438, #49, #626, #692, #436, #456, #7, #671, #204, #766, and #373. For the 20 records reviewed, the most recent risk assessment for these 20 individuals reported a change in status in 11 cases. These were for Individuals #312, #749, #553, #66, #590, #776, #167, #565, #204, #373, and #279. In nine (82%) the assessment process started within five days. Those that did not were Individuals #565 and #204. One of the 20 Individuals were new admissions, and initial risk assessments were done within the timeframe prescribed in policy. The remaining eight Individuals had recent risk assessments which did not indicate a change in status. Based on a review of nursing risk assessment records of a sample of six of these individuals (Individuals #279, #438, #49, #626, #692, and #436), two (33%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Those that did not were for Individuals #438, #49, #692, and #436. The compliance rate for this metric was reported as 83% in the last review. Refer to Section M of this report for additional information. Based on a review of PNMT records of a sample of eight of these individuals (Individuals #312, #749, #553, #66, #590, #776, #167, #565) for whom assessments had been completed to address the individuals' at risk conditions, six (75%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. Those that did not included Individuals #66 and #590, The compliance rate for this metric was reported as 60% in the last review. Refer to Section O of this report for additional information. Based on a review of risk records of six individuals (Individuals #456, #7, #671, #204, #766, and #373) with polypharmacy risk ratings, for whom assessments had been completed to address the individuals' at risk conditions, all six (100%) included a psychiatric assessment to assist the team in developing an appropriate plan. The compliance rate for this metric was reported as 100% in the last review. Refer to Section J of this report for additional information. In summary, in 14 of 20 (70%) instances the assessment(s) completed by the	Noncompliance

#	Provision	Assessment of Status	Compliance
		appropriate discipline were adequate to support the risk level determination. 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 20 Individuals discussed in Provision I.2, based on a review of 20 records for individuals determined to be at risk there was documentation that the Facility: • Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in 16 (80%) cases. This was not the case for Individuals #438, #49, #66, and #365. This compares to the 67% compliance rate noted in the last report by the Monitoring Team. • Implemented a plan that met the needs identified by the IDT assessment in 13 (65%) cases. This was not the case for Individuals #66, #776, #167, #438, #49, #692, and #436. This compares to the 67% compliance rate noted in the last report by the Monitoring Team. • Included preventative interventions in the plan to minimize the condition of risk in 16 (80%) cases. This was not the case for Individuals #438. #49, #692, and #436. This compares to the 75% compliance rate noted in the last report by the Monitoring Team. • When the risk to the individual warranted (eight cases), the Facility took immediate action in each (100%). This was the case for Individuals #312, #749, #553, #66, #590, #776, #167, and #565. This compares to the 100% compliance rate noted in the last report by the Monitoring Team. • Integrated the plans into the ISPs in 16 (80%) cases. This was not the case for Individuals #565, #438, #49, and #436. This compares to the 83% compliance rate noted in the last report by the Monitoring Team. • In 16 (80%), 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 #7, #438, #49, and #436. This compares to the 75% compliance rate noted in the last report by the Monitoring Team. • In 14 (70%), 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 #776, #167, #565, #49. This compares to the 67% compliance rate noted in the last report by the Monitoring Team. • Seven (35%) included the clinical indicators to be monitored and the frequency of monitoring. This was not the case for Individuals #438, #49, #626, #692, #436, #66, #590, #776, #167, #565, #456, #7, and #671. This compares to the 33% compliance rate noted in the last report by the Monitoring Team. In summary the overall average compliance score for the above eight metrics was 74%. Based on this review this Provision was not in substantial compliance.	Noncompliance

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment (07/03/2014) 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. Facility Presentation Book for Section J for July 2014 visit 4. DADS Policy and Procedures 007.3 Psychiatry Services (05/01/2013) 5. DSSLC CMGMT 20 Use of Restraint (revised 06/01/2014) 6. DSSLC CMGMT 21 Dental/Medical Sedation and Restraint (revised 05/15/2014) 7. Medical/Dental Desensitization Strategy Appointment Sheet (7/22/14) 8. Statement of Medical and Dental Desensitization Program Progress (7/22/14) 9. Draft form for tracking the efficacy of interventions to reduce the need for medical restraint (7/22/14) 10. Materials presented for ISP and Psychiatric Medication Review (PMR) meetings for Individuals #132, #230, #280, #411, and #488 that took place during the week of the visit 11. 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 Comprehensive Psychiatric Evaluation (CPE) 12. 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) 13. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Polypharmacy Review Committee (PRC), since the last compliance visit 14. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 15. A tabulation that compared rates of Facility use of polypharmacy over time 16. A separate list of individuals for whom each of the following was prescribed: a. Anticonvulsant medications used only for psychiatric indications b. Anticonvulsant medications used only for neurological indications c. Anticonvulsant medications used for both neurological and psychiatric indications d. Lithium e. Tricyclic antidepressants f. Trazodone g. Beta blockers being used as a psychotropic medication h. Clozaril/Clozapine i. Mellaril j. Reglan k. Anticholinergic medications l. Benzodiazepines

	17. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation (Total Intravenous Anesthesia [TIVA] or oral medication) 18. A list of all individuals screened for tardive dyskinesia with Dyskinesia Identification System Condensed User Scale manual (DISCUS) evaluations 19. DISCUS forms done over the past year that were rated "5" or higher 20. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effects evaluations 21. A list of individuals diagnosed with tardive dyskinesia and the Active Problem List (APL) for each of those individuals 22. Reiss Screens (both data and scoring sheets) done since the last review 23. A list of all individuals whose scores matched or exceeded Reiss Screen cut-off values per instrument guidelines 24. 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, individuals with various kinds of polypharmacy regimens, and individuals seen during the visit during PMR and ISP meetings. Individuals reviewed were #1, #117, #132, #151, #164, #168, #204, #230, #255, #280, #319, #370, #373, #411, #474, #488, #620, #671, #766, and #791. Materials reviewed were: a. Social History b. Most recent Comprehensive Psychiatric Evaluation (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Integrated Behavioral Health Assessment (IBHA), Positive Behavior Support Plan (PBSP) and Structural and Functional Behavioral Assessment e. Most recent Individual Support Plan (ISP) f. Most recent Annual Medical Summary g. Most recent Active Problem List (APL) h. All Psychiatric Medication Reviews (PMR) for the past six months i. All MOSES and DISCUS screenings for side effects, for the past six months j. All Quarterly Drug Regimen Reviews (QDRR) for the past six months k. Most recent Health Risk Assessment Rating tool and team meeting sheet l. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors, copies of the plan to reduce risk (ISP addenda) m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation p. Informed Consent (IC) for medications q. Most HRC review of psychotropic medications 25. Sample J2: Episodes of medical and dental restraint. Reviews were for Individuals #556 (2/6), #75 (4/30), #295 (4/30), #37 (3/12), #459 (4/16), #656 (5/14), #654 (4/29), #461 (4/10), #33 (4/2), #793 (5/5), #169 (3/19), #332 (3/18), #209 (4/7), #429 (2/24), #413 (4/10), #661 (4/30), #772 (3/19), #572 (5/28), #487 (5/12), #672 (4/23), #314 (2/13), #1 (5/15), #749 (5/21), #379 (4/30), #370 (5/5), #87 (2/26), and #152 (4/3). 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. 26. Sample J3: Psychotropic medications approved by the Behavior Support Committee (BSC) and the Human Rights Committee (HRC) during the last six months. Reviews were for Individual #10 (Ativan), #108 (Latuda and Saphris), #117 (Neurontin) #158(Lunesta), #181 (doxepin) #204 (Abilify and Clonidine), #222 (Benadryl, Unisom), #319 (Abilify and Zyprexa), #335 (cytomel) #388 (Geodon) #399 (Ativan) #474 (Abilify), #492 (Seroquel), #626 (Seroquel), #671 (Tegretol), #702 (Ativan and Latuda), #704 (Seroquel and Zoloft), and #783 (Zoloft) **People Interviewed:** 1. Ranganath Habbu, MD, Staff Psychiatrist, 07/21/14 2. Trenton Berrie, BCBA Interim Director of Behavioral Services, 07/21/14 and 0/7/22/14 3. Arifa Salam, MD, Lead for Section J 07/21/14 and 07/22/14 4 Donna Kimbrough, Behavior Analyst 7/21/14 5. Diane Porter, Nurse Case Manager Supervisor 07/21/14 6. Tony King, QIDP Coordinator 07/21/14 7. Amy Anthony, Behavior Analyst 07/21/14 8. Serena Knox, Settlement Agreement Coordinator 07/22/14 9. Satyajit Satpathy, MD, Staff Psychiatrist 07/22/14 10. Amy Anthony, Behavior Analyst 07/22/14 11. Katy Atcheson, Behavior Analyst 07/22/14 12. Sibylle Graviett, RN Nursing Compliance Officer 07/22/14 **Meeting Attended/Observations:** 1. PMR clinic with Dr. Habbu, 07/21/14 2. PMR clinic with Dr. Satpathy, 07/21/14 3. Integrated Morning Report, 07/21/14 4. P&TC meeting, 07/22/14 5. ISP Meeting, Individual #280, 7/22/14
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J. 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 provided a self-rating stating why it believed compliance had been achieved. The Facility Self-Assessment for Section J relied on two sources of data and data analyses:

	First, there were the three audit tools were used by the Department of Psychiatry. Two were tools used by the 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, such as history of present illness, diagnosis, and case formulation. 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. 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. Tabulations of monitoring were provided to the QA/QI Council meetings, and results were reported there in terms of percentage of accomplishment from month to month. Data demonstrated both areas of strength (for example Provisions J1, J2, which exceeded 80% each month) and areas where more efforts were needed (for example Provision J8, where for the six-month period of Jan-June 2014, ratings reached 80% for only three of six (50%) months. Second, the Psychiatry Department conducted an internal review based on record reviews for 25 of 232 (11%) of the total number of individuals who received psychotropic medications, for the presence of key items important for compliance. In some cases, reported data was a subset of the data for the tools listed above that focused on tools used state-wide. In other cases, reported data was specific to DSSLC processes. For example the Self -Assessment for Provision J13 examined whether IBHA reports contained a section that described the psychiatric symptom monitoring method and symptom severity scale. Overall, the Monitoring Team found that current methods allowed the Facility to correctly detect where progress had been made. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance. The Action Steps appeared to be relevant to achieving compliance, and defined the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. In some cases the Action Steps were very broad and it would have been better to be more detailed about the actions to be taken. An example was Provision J4. The Action Plan mentioned the restraint checklist documentation but it did not address how the Facility planned to resolve the fact that the duration of monitoring listed on the checklist does not correspond to the nursing protocols used at the Facility. For provisions that had been found in compliance, the Action Plan for Section J included actions to maintain compliance. It was valuable for the Facility to recognize and act on the need to maintain compliance, and to implement actions to prevent decline in performance. The Facility indicated it continued to be in compliance with Provisions J1, J2, J5, J7, J10, J11, J12, J14 and J15. The Monitoring Team concurred.
	Summary of Monitor's Assessment:

	At the time of the visit, nine of fifteen provisions were in substantial compliance. No new provisions came into compliance during the visit, but progress was noted in many, and several are close to reaching substantial compliance. The Facility had improved its methods for quality assurance of psychiatric practices. That supported an effective dialogue between the Monitoring Team and the Facility about where efforts for improvement should be focused. Provisions J1, J2, J5, J7, J10 J11, J12, J14 and J15 remained in substantial compliance. For Provision J6, improvements in internal quality assurance have helped raise the quality of psychiatric assessments, which were close to levels needed for substantial compliance. For Provisions J3, J8, J9 and J13, additional work was needed to successfully complete the transition to the newer treatment plan and medication monitoring formats. Provision J4, which focused on medical restraint, continued to lag behind others. For that Provision, the Facility developed new strategies to reduce the need for restraint. The strategies were promising. Areas that needed improvement included: • Psychiatric Support Plan documentation of the non-pharmacological supports that are were place, to minimize the need for psychotropic medication • Nursing documentation of monitoring for safety by during medical restraints • Development, implementation, and monitoring for efficacy of strategies to minimize the need for medical restraints • Inclusion of integrated behavioral health information in the ISP process and in Individual Support Plans • Identification of which modalities of behavioral health treatment (behavioral, pharmacological or other, in combination or alone) are offered to individuals, and why • DISCUS screenings following a change in neuroleptic dose

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	During the review period there were no changes in the psychiatric staffing. Drs. Ranganath Habbu, Arifa Salam and Satyajit Satpathy continued their work as full time staff psychiatrists. Dr. Salam was the Lead Psychiatrist for the Facility. Dr. Robert Harden and Dr. Howard Lagrone continued to be employed as contract psychiatrists. All psychiatrists had current licensure in the State of Texas. Drs. Harden, Lagrone, Salam and Satpathy were Board Certified in Psychiatry, and Dr. Habbu was Board Eligible. The psychiatrists' credentials all met the requirements of the SA. The psychiatrists' training and experience were detailed in previous reports of the Monitoring Team. During the tour the Monitoring Team observed the work of the psychiatrists during their psychiatric clinics and during the infirmary morning meeting. The Monitoring Team attended an ISP of an individual who received support from the Lead Psychiatrist, and observed her work during that meeting.	Substantial Compliance

		The Monitoring Team found that the psychiatric staff at DSSLC consisted of qualified professionals, who participated meaningfully in the interdisciplinary process.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	At the time of the Monitoring Team visit, 232 of 458 (51%) individuals who lived at the Facility received psychotropic medications. All 232 individuals (100%) received services from a psychiatrist and had CPEs in place. The DSSLC Psychiatry Policy states that in years subsequent to the initial evaluation, updates to the initial evaluation may be done based on the clinical judgment of the psychiatrist. Facility practice was to update each psychiatric evaluation, prior to the individual's annual ISP. In the updates, needed information from previous evaluations was brought forward, new information added, and a new mental status examination was completed. All psychiatric evaluations, initial and updates, were to be done in Appendix B format (see Provision J6). During the visit, the Monitoring Team assessed continued compliance with the overall diagnostic practices. This was done by observing the daily work of psychiatrists in PMRs, at Integrated Morning Report meetings, and at committee meetings such as the PRC and P&TC. The Monitoring Team conducted case reviews for the twenty individuals in Sample J1. The sample included individuals considered by the Facility to be stable on their current psychotropic medication, individuals who had been prescribed new medications due to clinical difficulties, individuals with various kinds of polypharmacy regimens, and individuals seen during the visit during PMR and ISP meetings. The Monitoring Team also reviewed medical and psychiatric materials (CPEs) for the nine individuals admitted to the Facility during the review period who took psychotropic medication prior to admission, received CPEs on admission, and were referred to PMR clinics. Similarly, the Monitoring Team reviewed CPEs for two individuals who lived at the Facility and were referred to psychiatry due to a change in their behavioral status (see discussion below). <u>The process in place for evaluation and diagnosis:</u> Psychiatrists interacted with individuals and Interdisciplinary Team (IDT) members in many settings. As reported in the self-assessment, psychiatrists were now regular attendees at annual ISP meetings, and they participated in both routine and crisis management IDT meetings as the circumstances required. Psychiatrists at the Facility all conducted scheduled meetings with individuals in the psychiatry clinic. These meetings were known at the Facility as Psychiatric Medication Reviews (PMRs) and Quarterly Psychiatric Reviews. These appointments were also attended by several IDT team members, including the Qualified Intellectual Disability Professional (QIDP), psychologist /behavior analyst, nurse case manager, and selected DCPs who knew the individual well. Appointments typically lasted about 45 minutes. All	Substantial Compliance

		individuals assigned to a psychiatrist for ongoing care met with the psychiatrist at least quarterly, and they often met monthly. As the clinical circumstances required, psychiatrists observed and/or interviewed individuals, sometimes in an office setting and sometimes at the individual's workplace or other setting. <u>Review of Diagnoses during PMRs:</u> Individuals #132, #230, #411, and #488 had PMRs during the visit and the Monitoring Team attended the meetings. One of the items reviewed at each PMR was the individual's diagnosis. To assure that this was done, the form completed during the PMR had an item that inquired whether the diagnosis had changed. Individual #230 was diagnosed with Autism. She had also previously been diagnosed with obsessive-compulsive disorder but her rigidity (for example her difficulty with any changes in her routine) were now attributed to her Autism and the second diagnosis had been withdrawn during a previous PMR There was active discussion during the PMR about management of behaviors associated with the diagnosis of autism, including the cognitive rigidity that was the source of the previous diagnosis of obsessive compulsive disorder. Individual #132 was diagnosed with Alzheimer's Dementia. The discussion about the management of her difficulties, for example whether or not she should continue with a medication used to minimize the progression of the dementia, was informed by the accepted fact that in advanced dementia the risks of such medications typically outweigh the benefits. There was discussion about how advanced the dementia was and that set up a discussion about medication discontinuation. Individual #488 was diagnosed with bipolar disorder and there was active discussion about the mixed affective presentation of the disorder. He was diagnosed with both depression and dementia, and he was treated with Aricept, Zyprexa and Zoloft. The discussion was guided by the knowledge of both dementia and bipolar disorder and the linkage of the diagnoses to the particular medications. No changes were made in the medication at the time of the PMR. <u>Individuals newly admitted to the Facility.</u> Individuals #7, #142, #180, #436, #456, #477, #542, #671, and #744 were admitted to the Facility during the review period. They all took psychotropic medications and had CPEs. All had CPEs done during the first 30 days of admission, prior to the ISP meeting. <u>Individuals newly referred to psychiatry.</u> There were two new referrals for change of status between 01/01/14 and 06/01/14. Individual #503 was referred due to gradual cognitive decline. The individual carried the diagnosis of Down syndrome. He was evaluated by neurology and had a dementia	

		screening questionnaire. Due to a change in behavioral status the individual received a Reiss screen, which was positive with a score of 16/26. He was seen by psychiatry and had a CPE that documented a cognitive disorder with possibility of Dementia. The psychiatrist commented on possible interventions to be explored further with the family. Individual #218 also had Down syndrome, had been seen by neurology, and the workup included an imaging study that was consistent with dementia. He was seen by a psychiatrist, who recommended follow-up with psychology, PT and OT. Medications were not recommended due to advanced stage of the dementia. <u>Facility process to track diagnoses and diagnostic updates:</u> • Facility-wide tracking: The Department of Psychiatry maintained a spreadsheet (referred to internally as a database). It was maintained by the psychiatry assistants. The spreadsheet listed the individual's diagnosis, the Facility psychiatrist responsible for care, and psychotropic medications. The Psychiatry Department Assistants updated it whenever the psychiatrist made a change in the diagnosis. Information from the database was available to appropriate Facility staff to assure that psychiatric information was cited correctly by members of other departments. For each of the 20 individuals in Sample J1 (100%), the Monitoring Team confirmed that the spreadsheet correctly described the psychiatrist's most recent psychiatric documentation (CPE, PMR, etc.). • Tracking in Individual's records: Psychiatric diagnoses were included in the Active Problem List (APL) that listed all medical diagnoses. Each time the psychiatrist made a change in an individual's diagnosis, that diagnosis was also updated in the APL. The Monitoring Team examined the 20 clinical records for the individuals in Sample J1, and compared the current psychiatric diagnosis and the APL. For 18 of 20 (90%) individuals, the two sources matched. In two of twenty (10%) the APL had not yet been updated. <u>Monitoring Team's Compliance Rating</u> Overall, the Facility has a good process in place for conducting psychiatric evaluations. The Facility continued the practices for which it has been rated with substantial compliance in recent visits and that status is continued.	
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	<u>PBSP documentation</u> Psychotropic medications were given to 232 of 458 (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. As described in the Monitoring Team report for the previous visit, the process of transition to the IBHA format began in late 2013. As each individual's annual plan became due for renewal, it was rewritten and presented in the new format. Accordingly, the process of transition should be complete by the end of 2014. As the name indicated, the IBHA was the repository for behavioral	Noncompliance

	specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	health information from psychiatry, psychology, and other behavioral health disciplines. IBHAs were organized using the following format: • History, including behavioral treatment history • Current Status, including DSM diagnoses • Current status/services, including psychiatric medication and behavioral treatments • Psychiatric assessments, including the psychiatric case formulation. The template for the IBHA also included a table of the individual's psychiatric target symptoms, which were the focus of medication treatment(s). The table was accompanied by operational definitions of those target symptoms and severity codes that were used for graphs providing symptom tracking over time • Behavioral assessments, including tools that explore the etiology of learned challenging behaviors • Integrated findings, including a section on the differentiation of learned behavior and psychiatric symptoms and an integrated case formulation • Recommendations 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. Some individuals who took psychotropic medications were assessed not to need a PBSP. For those individuals, the behavioral treatment program was presented in the form of a Psychiatric Support Plan, organized using the following format: • Diagnostic Information • Purpose/ Fundamental Outcome • Description Background and History • Pertinent Medical/Dental • Intellectual Assessment • Adaptive Skill Assessment • Functional/Structural Assessment • Non Pharmacological Treatment History • Data Presentation (Psychiatric treatment tracking, previous PBSP target behavior data, anecdotal data) • Counseling Supports • Psychiatric Case Formulation • Integrated Case Formulation • Recommendations • Restrictive Practices/Attempts at Less Restrictive Practices The PSP was followed by a list of the psychiatric supports that were in place.	

		In the Self-Assessment the Facility reported continued improvement in the inclusion of relevant psychiatric information in reviewed IBHAs. The Facility did not self-rate for compliance at this time, and cited the need for further improvement in the quality of psychiatric assessments and IBHAs. The Monitoring Team reviewed the behavioral treatment plans for the 20 individuals in Sample J. Sixteen of 20 individuals (80%) had plans that were written in the new format, and four of 20 (20%) were PBSPs written in the older format. For the 16 individuals who had plans written in the new format, 14 of 16 (88%) had IBHAs, and two of 16 (12%) had PSPs. The individuals who had PSPs did not have IBHAs. For the group of 16 individuals who had plans that were written in the new format: • History, including behavioral treatment history was present for 16 of 16 (100%) individuals • Current status/services, including psychiatric diagnosis, was provided for 16 of 16 (100%) individuals. In each case the documents included 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 most current psychiatric evaluations • Identification of the problem and need for behavior supports: All IBHAs listed behavioral supports in the behavioral treatment history section of the document, and more details were provided in the PBSPs. In the two Psychiatric Support Plans, the assignment of supports was discussed in the psychiatric case formulation and integrated case formulation section o For Individual #230, the Psychiatric Support Plan (implementation date 10/21/13, ISP date 09/23/13) stated: "*The PBSP dated 11/25/08 targeted physical aggression to others, stealing, and anxiety. Her main problems were impairment in reciprocal social interaction associate with impairment in verbal skills and stereotypical interest and activity pattern. She was unable to adjust to minor environmental changes such as changes in daily routine. For example, she refused or become agitated when she had to go to medical appointment during work time. She showed some preoccupation in orderliness and rigidity in adjustment. In her PBSP dated 11/19/09, she was targeted for agitation which was characterized as pacing from room to room (especially before she seems to look for taking others' items) or her voice getting louder when her schedule is disrupted. Her parents were very adamant about not decreasing Paxil at that time for the past few years due to their past experience of deterioration in (the individual's) conditions. In 2010, the psychiatrist changed her diagnosis to Autistic Disorder. For the past year, (the Individual's) difficulty with adjusting to changes has decreased. However, she continued to exhibit sporadic agitation and aggressive episodes, which is*	

		mostly related to impairment in social interaction and lack of verbal skills from Autistic Disorder. Her problems of agitation and stealing are low in frequency and mostly redirectable. Therefore, it is much better practice to track psychiatric symptoms to see if the medication is effective to determine (the individual's) progress or deterioration. ○ For Individual #132 the Psychiatric Support Plan (implementation date not provided, ISP date 01/29/14) stated: *"Per Annual Psychiatric Summary dated 02/07/2013: … Based on symptoms of cognitive and functional impairment (whining, crying and irritability resulting in increased episodes of aggression toward staff, decreased communication with others and increased self-talk of past/childhood experiences, episodic confusion and disorientation, lack of initiation and interest, uncooperative behavior and refusal to take medication and loss of skills) the diagnosis of Alzheimer's dementia is maintained. Positive family history of dementia, high incidence of Alzheimer's dementia with individuals with Down's (sic) syndrome and absence of acute medical/vascular/neurological problems, indicated Alzheimer's dementia as the most likely diagnosis. Treatment with Aricept has been beneficial with noticeable improvement in mood/behavior and cognition and will be continued to slow the disease progression and to enhance cognitive functioning. (The individual) will continue to have PBSP for target behaviors of PAO and VDB and to encourage positive behavior of choosing break. Her psychologist also monitors psychiatric symptoms and medication efficacy via tracking and data collection. (The individual's) health status, laboratory work, and MOSES are monitored in collaboration with her PCP and RN case manager. (The individual) should be encouraged to participate in routine activities, structured training program, and mentally stimulating exercises to help reduce the risk of functional and cognitive decline."* For these two individuals with Psychiatric Support Plans, the Monitoring Team assessed that there was not adequate documentation to support the apparent decision not to provide a PBSP. To the contrary, for Individual #132, the above citation explicitly stated that a PBSP <u>was</u> needed. It is of course possible that the citation was an inadvertent inclusion of an outdated and older document. If so, that only emphasized the need for careful documentation regarding the basis for a decision to rely on psychiatric monitoring alone. The Monitoring Team explored what other forms of active behavioral treatment were in place for the two individuals. Neither of the two individuals had counseling supports; ISPs for the two individuals did not document other forms of active behavioral supports. It is of course possible that at the time the Psychiatric Support Plans were	

		developed, the two individuals were not experiencing challenging behaviors that warranted active intervention programs. For such individuals the Facility might explore the development of other support programs by the Behavioral Health/Psychological Services Department that would more directly address the requirements of Provisions J3 (and Provision J9). Details on the *mentally stimulating exercises to help reduce the risk of functional and cognitive decline* for Individual #132 were not provided. Perhaps they were (or were part of) an appropriate support program. • Information from behavioral assessments: psychiatric assessment/case formulations (CPEs, functional assessments, IQ testing) were provided in all cases. For more discussion of those assessments, please see Provisions J6 and Section K. • Psychotropic medication information psychiatric case formulations were provided for 16 of 16 (100%) individuals. For all individuals, the information was consistent with the information in the psychiatry department database for psychotropic medications. • Differentiation of learned problem behaviors and psychiatric symptoms/behavioral characteristics: These were present in 16 of 16 (100%) of the records; they typically consisted of one or two paragraphs. Discussion of what the Monitoring Team expected in terms of quality for these statements has been included in each of the recent reports of the Monitoring Team. For individuals in Sample J1, the Monitoring Team found that 9 of 16 (56%) statements provided sufficient clarity to allow the Monitoring Team to understand how particular medications and behavioral interventions were linked to the IDT's understanding of the individual. • Monitoring for treatment efficacy: Data-based monitoring of medications for efficacy was a key element of psychiatric treatment. Treatment plan information on how medications were to be tracked for efficacy was contained in 16 of 16 (100%) of the treatment plans. Information on how the tracking for efficacy was implemented is included under Provision J13, which focused on medication treatment plans. Some work remained to be done on the development of meaningful tracking. For example, there remained a need to link at least one of the selected targets to the underlying psychiatric diagnosis. That was needed to assure that the medication was not be used solely for behavioral control; for more information, see Provision J13. Overall, the IBHA format and structure was useful, since it directed the psychiatrist and psychologist to address matters of integrated care needed for this Provision. In the Self-Assessment the Facility stated that improvement is needed in the quality of the treatment plans, as detailed above. The Monitoring Team agreed with that. <u>Appropriate use of medication:</u>	

		The Monitoring Team reviewed the records for the 20 individuals in Sample J1. That sample included Individuals #132, #230, #411, and #488, who had PMRs during the visit and Individual #280 who had an ISP during the visit. The Monitoring Team observed those PMRs and the ISP. The Monitoring Team found no evidence of inappropriate use of medication. The quality of Facility monitoring for appropriate use of medications was generally good, although in some areas improvements were still needed. Detailed analyses and comments regarding the quality of the monitoring are provided under Provision J2 (relationship to psychiatric diagnosis), Provision J8 (overall integration of medication use with the overall support team), Provision J10 (risk/benefit and risk reduction), Provision J11 (polypharmacy practices), Provision J12 (side effect monitoring), Provision J13 (tracking for medication efficacy), Provision J14 (consent) and Provision J15 (coordination with neurology). <u>Medications used for staff convenience</u> The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PMRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience. <u>Medications used for punishment</u> To determine whether this was done, the Monitoring Team considered observations made during the tour, and reviewed the records of the 20 individuals in Sample J1. There was no evidence that medications were used for punishment. <u>Chemical Restraint</u> There was one episode of chemical restraint at the Facility during the review period. That was for Individual #671 on 2/23/14. Psychiatry participated in the management of the restraint (including medication orders) and the subsequent review of the restraint. Two post chemical clinical reviews were done. The first was done by the treating psychiatrist on 2/24/14. Since the record was not available at the time, the detailed review was documented on an IPN. The review was detailed and comprehensive. An additional review was done by another psychiatrist on 3/11/14 and was documented on a Post Chemical Restraint Clinical Review form. The reviewing psychiatrist concluded that "appropriate consultation and interventions (were provided), given the clinical circumstances." The Monitoring Team concurred. <u>Monitoring Team's Compliance Rating</u> Progress was noted in the presentation of information and the overall use of medication. The introduction of the IBHA was a positive step, since it organized and integrated behavioral treatment information well. Psychiatric Support Plans needed to present clearly how needed non-pharmacological supports were provided. For now, the Provision remains in noncompliance.	

J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Monitoring for Safety during Medical Restraint</u> During the review period the Facility updated CMGMT-21 (revised 5/15/14), which clarified the use of medical restraint. The revisions included the introduction of a new order form for medical/dental restraint. It included: • Clinic justification for the use of restraints/support • Type of restraint • 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. • Assessment type (vital signs, mental status, other) • Additional instructions for restraint specific patient care The Facility provided the Monitoring Team with a list of all Medical and Dental restraints from 01/10/2014 through 05/23/2014 that listed 260 episodes of medical restraint that used chemicals. Intravenous sedation (TIVA) was used for 148 of 779 (19%) dental procedures, and oral pretreatment sedation was used for 40 of 779 (5%) dental procedures. Oral pretreatment was used for 72 medical procedures. Information on the total number of medical procedures was not provided. 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 signs 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. Sample J2 was selected from the list of individuals who had medical restraint in the last six months. It represented 10% of the individuals for whom medical restraint was used (Sample J2 is defined above in the Documents Reviewed section). For these individuals, the physician's orders were reviewed as well as the documentation of the monitoring. For 18 of 27 (67%) episodes of restraint the physician specified the schedule of monitoring required or specified facility monitoring that was followed. In 11 of 27 (41%) episodes of restraint the physician specified a type of monitoring that was different than the facility policy. In 18 of 27 (67%) medical restraints, the appropriate monitoring was completed as required by the facility policy or as the physician prescribed. 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. Such information was not always present.	Noncompliance

		Strategies to reduce the need for pretreatment sedation Over the review period, the Facility continued to develop strategies to reduce medical and dental restraint. During the visit the Facility provided documentation that between April 2013 and April 2014, 149 individuals were identified as having undergone sedation for routine medical/dental procedures. The Facility provided the Monitoring Team with a list of 30 individuals who had plans in place to reduce the need for pretreatment sedation, During the visit the Facility met with the Monitoring Team to describe the ongoing effort to develop strategies to reduce the need for pretreatment sedation for all individuals who needed them. A number of efforts were underway. First, the Facility now tracked all uses of medical restraint as they occurred. That helped the Facility identify individuals who needed to have strategies developed but did not have them. A BCBA was now assigned to track such individuals and their status as IDTs developed needed strategies and the strategies were reviewed and approved by the IDT, the BSC, and the HRC. During the visit the Monitoring Team again identified the need for data-based analyses of the efficacy of the strategies used to reduce the need for medical restraint. In response, the Facility developed a draft form to track efficacy. The form tracked (1) the strategy to reduce the need for sedation/restraint, (2) whether the strategy was employed before/during a pretreatment episode, and the (3) individual's reaction to the strategy. In addition, the Facility continued to track numerous items about restraint in the Integrated ISP Audits (completed by the Quality Assurance department) that addressed both discussion and documentation about restraints over the prior year, and the needs for action plans related to desensitization or alternative treatments/strategies/supports. Records of individuals from Sample J2 were reviewed for efforts to reduce the need for sedation. Twenty five of 27 (93%) individuals showed that there had been appropriate authorization (i.e. adequate consent and HRC approval), zero of 27 (0%) individuals included appropriately developed strategies to minimize or eliminate the need for restraint; and 0 of 27 (0) of the treatments or strategies developed to minimize or eliminate the need for restraint had been implemented as scheduled. Monitoring Team's compliance rating The Monitoring Team noted improvement in monitoring for safety during pre-treatment sedation although the forms used by the Facility to enter data on monitoring did not allow nurses to enter data for the full duration of the nursing protocols in use. Difficulties with development, implementation and tracking of supports to minimize the use of restraint persist. For those reasons the provision remains in noncompliance with the requirements of the provision.	
J5	Commencing within six months of the Effective Date hereof and with	The Facility continued to employ three full time staff psychiatrists and one part-time contract psychiatrist for a total of 3.5 full time equivalent positions.	Substantial Compliance

	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.	Dr. Arifa Salam continued as the Lead Psychiatrist. In this role she was responsible for many Facility-wide activities, which included management of Facility-level reviews such as polypharmacy and management of the Facility-level reviews of individuals known to have tardive dyskinesia. Dr. Salam also had a clinical caseload of 55 individuals. Drs. Satyajit Satpathy and Ranganath Habbu continued as a full time Staff Psychiatrists. Dr. Satpathy had a clinical caseload of 78 individuals and Dr. Habbu had a clinical caseload of 75 individuals. Dr. Robert Harden had worked at the Facility for many years, and he continued as a part time contract psychiatrist. Dr. Harden had a caseload of 24 individuals. Dr. Howard Lagrone continued as a part time contract psychiatrist. He did not carry a clinical caseload and his work focused on quality assurance. The combined effort level of the psychiatrists was 3.5 full time equivalents. Psychiatrists participated in routine clinical activities, which included PMRs, QPRs, ISPs and neurology clinics. Psychiatrists also attended medical staff meetings, and participated in committees such as P&T and Polypharmacy. In their day-to-day work, the psychiatrists received administrative support from Ms. Brenda Morris and Ms. Devon Wince. The psychiatric assistants provided the psychiatrists with support such as scheduling and preparation of materials and documents for PMRs and other scheduled activities. The psychiatric assistants also prepared summaries of meetings and reports, and they maintained departmental records. Psychiatry assistants also participated in neurology/psychiatry conferences, tracked the information reviewed, and brought that information to the relevant PMR meetings. The Psychiatric assistants helped the psychiatrists track labs and other clinical materials. The Monitoring Team concurred with the Facilities that that there was a sufficient number of board certified or board eligible psychiatrists to provide the services required by Section J of the SA.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as	<u>Appendix B Evaluations Completed</u> At the time of the visit psychiatric services were provided for 232 of 458 individuals (51%) who lived at the Facility. Two hundred and thirty two (100%) of those individuals had a CPE in the Appendix B format in place. DADS policy for psychiatry required annual updates of the CPEs. That had long been the practice at the Facility, and each individual's CPE was reviewed and updated at the time of the annual ISP. Since the last visit, there were two referrals to psychiatry that resulted from change-of-status evaluations. Each received an Appendix B CPE. There were also nine admissions	Noncompliance

described in Appendix B.

to the Facility of individuals who received psychiatric medications at the time of admission. Those individuals also received Appendix B CPEs (see Provision J2).

Status of work to date on the Provision

The last report of the Monitoring Team noted that there had been much improvement in the quality of the Appendix B CPE but there remained a need for improvement in the quality of documentation in CPEs.

During the review period, improvement in the quality of the CPEs was the focus of the Facility. In the self-assessment the Facility informed the Monitoring Team that an audit was conducted of 25 records, using the DADS CPE audit tool. Results were reported for the History of Present Illness (HPI), Case formulation, and Treatment Recommendation sections; these sections contained information that had been a focus of Monitoring Team comments. The results of the audit showed that 76% of records were assessed as adequate in the HPI section, 60% were adequate for treatment recommendations, and 32% were adequate for case formulations.

During the latter part of the review period the Facility expanded the role of the outside consultant. Until that point his work consisted solely of reviews of psychiatric evaluations. That work proceeded in parallel to the ongoing work of the Facility psychiatrists. In contrast, in Spring 2014 the reviewing psychiatrist stepped into the active work process when the circumstances warranted: When the reviewing psychiatrist encountered an evaluation he thought did not quite meet the high required standards, the author received the review and discussed the reviewer concerns in a 1:1 meeting. The evaluation was then rewritten by the Facility psychiatrist with the reviewer's comments in mind.

The Facility provided the Monitoring Team with data to show audit results before and after this intervention was made:

CPE section	Jan – May 2014 n=25	June 2014 n=16
History of Present Illness	19 of 25 (76%)	13 of 16 (81%)
Diagnosis	19 of 25 (76%)	14 of 16 (87%)
Treatment Recommendations	15 of 25 (60%)	15 of 16 (94%)
Case Formulation	8 of 25 (32%)	10 of 16 (62%)
Total score	15 of 25 (60%)	15 of 16 (94%)

The results show a marked improvement for June 2014.

		Monitoring Team Review The Monitoring Team reviewed the records of the 20 individuals in Sample J1. Twenty of 20 (100%) individuals had either a CPE or a CPE update during the past 12 months. The Monitoring Team review found that the quality of the evaluations continues to improve, particularly in the area of diagnostic justification. Increasingly, the evaluations/annual review cited not only broad terms such as symptoms of anxiety, but descriptions of the behaviors that were the basis for the characterizations. Diagnoses were increasingly accompanied by descriptions of the ways in which the individual met the DSM criteria for the various diagnoses; as outlined in previous reports, that is one of the ways that the Monitoring Team determined whether diagnoses are justified. In the current sample, the Monitoring Team found that the diagnoses were justified in 15 of 20 (75%) of the individuals. In the following paragraphs the Monitoring Team provides examples from the sample to highlight what the Monitoring Team considered acceptable and non-acceptable items from the CPEs. • Individual #620: The CPE summarized the difficulties of a woman who had a disorder characterized by extreme restlessness, agitation, and self-injurious behavior. At one time she was diagnosed with premenstrual dysphoric disorder. More recently she was diagnosed with major depressive disorder. At the time of the evaluation the disorder was in remission and the disorder was properly coded to reflect that. The HPI nicely brought her presentation to life with details of the "disastrous" results of attempts to discontinue the Prozac that she took. The document left no doubt that the use of the medication was justified. However, the cited symptoms could be the basis for characterization/diagnosis as an affective disorder or an anxiety disorder. Moreover, SSRIs – albeit not usually Prozac - can be used to treat both anxiety and affective disorders. Given that, the psychiatrist should have discussed how the symptoms met the DSM requirements for the diagnosis of major depression at the time she was symptomatic. • Individual #204: The individual was diagnosed with both autism and bipolar disorder manic type and Tardive Dyskinesia. The psychiatrist provided the needed discussion about the differential diagnosis, and the benefits of the treatment with both Zyprexa and Depakote. The psychiatrist wisely described that the dyskinesia became increasingly evident when Depakote was discontinued and Zyprexa was reduced. The dyskinesia diminished when Depakote was reinstated and Zyprexa was increased. The information provided by the psychiatrist made it clear that medications were needed. But the use of antipsychotics needed more explanation. Given the dyskinesia, there should have been information whether Depakote monotherapy was tried as alternative to the use of antipsychotics. More generally, there needed to be an explicit statement that the assessment had been made that the benefit of the continued use of Zyprexa justified the risks in face of known Dyskinesia. Perhaps that information was available elsewhere in the record, but in	

		the opinion of the Monitoring Team the information was sufficiently important to be included in each year's annual summary. • Individual #766: The justification of the diagnosis of schizoaffective disorder, bipolar type was adequate and the needed justification for the addition of primary insomnia was provided. The current citation of this case is provided since the DSM criteria for diagnosis of schizoaffective disorder are quite demanding. In the opinion of the Monitoring Team the psychiatrist provided the right amount of detail needed to support the use of the diagnosis in question. • Individual #1: The individual appeared to have a mood disorder that was not evident for many years since she was treated for epilepsy with a medication that was also an antidepressant. When that medication was no longer needed for epilepsy, the medication was removed and the individual's mood became unstable. The psychiatrist described how the mood disorder became apparent at that time, and provided the needed details to justify the specific diagnosis. Many symptoms resolved once a medication was re-introduced. • Individual #671: The individual was newly admitted in February 2014. The evaluation was not sufficiently detailed, even allowing for the fact that she was newly admitted. For example, the evaluation stated that the Individual was diagnosed with autism at named treatment center between 2010 and 2013 but details were not provided. The psychiatrist should have noted whether needed documents from that facility had been requested to answer needed diagnostic issues. • Individual #319: The diagnosis of autism was well supported by the details. • Individual 791: This was an individual for whom a better-organized discussion of possible diagnosis is needed. The Individual had a life-long history of psychiatric treatments and lengthy institutionalizations. The psychiatrist noted a history of impulsive and aggressive behaviors/assault, aggression/violence and threat of harm toward self and others. The psychiatrist noted that records did not include documentation of mania/hypomania, depression, or symptoms such as nightmares. Flashbacks, excessive anxiety and avoidance that might suggest post-traumatic stress were not present. The impulsive sexual and aggressive behaviors were not associated with a mood disturbance. The baseline was hard to establish due to ongoing treatment with medication for many years. The above was a very good starting point with which to begin re-establishing a justified diagnosis. However, the psychiatrist chose to continue the existing diagnosis of Bipolar II disorder which, as above, had very little support. It would have been better to list the diagnosis as "history of Bipolar II disorder"; that would not necessitate automatic discontinuation of medications that had long been in place, but it would have highlighted the need to challenge the various medications, probably one at a time, once good tracking measures were in place. That would help answer both diagnostic questions, and establish that the treatments were needed. <u>Monitoring Team's Compliance Rating:</u>	

		The results of both the Facility quality assurance program and the review of the 20 individuals in Sample J1 indicated that the effort to bring the quality of the psychiatric evaluations to the required standards was nearing its goals, but some work remains. For this review period the provision remains in noncompliance.	
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> As described in prior reports of the Monitoring Team, all individuals who lived at the Facility were either treated on an ongoing basis in the psychiatry clinic and had CPEs in place, or they had been evaluated with a Reiss Screen. Individuals who lived at the Facility in early 2013 who needed screens received them between 12/01/12 and 03/31/13. Individuals admitted since then were screened on admission. The screenings were done in accordance with the requirements spelled out in the Settlement Agreement, and a successful screening was a basis for existing findings of substantial compliance with the requirements of the Provision. <u>Reiss Screens for Recent Admissions</u> Between 01/01/2014 and 06/01/2014, there were 15 admissions to the Facility. Nine of the individuals took psychotropic medications on admission and they did not need Reiss screens since they received CPEs (see Provision J3). Six of the individuals were not prescribed any psychotropic medication on admission and they did need Reiss screens. Six of six (100 %) of these individuals had Reiss Screens completed. The Reiss screens were administered and scored using software provided by the developer of the tool. The results of the Reiss Screen for these six individuals did not indicate a need for psychiatric referral. One of the six Reiss Screens was not completed within thirty days, although it was completed soon thereafter. The cause of the delay was identified and corrected. Nine out of 15 individuals admitted since January 2014 took psychiatric medications. All nine had CPEs that were completed within 30 days of admission. The Monitoring Team examined the CPEs. The overall quality was good. Diagnoses were justified for seven of nine (77%) evaluations, and case formulations were also adequate for seven of nine (77%) evaluations. <u>Reiss Screens for Change of Status Evaluations</u> The process in place for a behavioral change of status evaluation required completion of a Reiss screen and a psychological assessment or update of the current assessment, completion of a dementia screening tool if that was appropriate, an IDT meeting, and then a consultation request for psychiatry if the Reiss Screen was positive. Evaluation was scheduled as soon as possible but no later than 30 days from the receipt of the consultation request. There were two new referrals for change of status between 01/01/14 and 06/01/14. Individual#503 was referred due to gradual cognitive decline. The individual carried the	Substantial Compliance

		diagnosis of Down syndrome. He was evaluated by neurology and had a dementia screening questionnaire. Due to a change in behavioral status the individual received a Reiss screen which was positive with a score of 16/26. He was seen by psychiatry and had a CPE that documented a cognitive disorder with possibility of Dementia. The psychiatrist commented on possible interventions to be explored further with the family. Individual #218 also had Down syndrome, had been seen by neurology, and the workup included an imaging study that was consistent with dementia. He was seen by a psychiatrist, who recommended follow-up with psychology, PT and OT. Medication was not recommended due to advanced stage of the dementia. Due to an oversight, Individual #218 was referred to psychiatry without having had a Reiss screen first. The Monitoring Team discussed the matter with the Facility. The Facility was already aware of the problem and had clarified to IDTs when Reiss screens were needed. In addition to the Reiss screens that resulted in positive screens and referrals to psychiatry, Individuals #208, 435, and #793 were also screened for behavioral changes. Those Reiss screens were negative and no referrals were made to psychiatry. <u>Monitoring Team's Compliance Rating</u> 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. An adequate procedure was in place for the use of the Reiss Screen during evaluations for a behavioral change of status. During the current visit the Monitoring Team confirmed that Reiss Screens were completed for all individuals who required them, with the exception of the error made for Individual #218. The Monitoring Team found that the Facility has continued to meet the requirements of the Provision and remained in 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. 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 in settings that promoted integration of care. These included: • PMR clinics that 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 J2, J10, J12 and J13. During the visit the Monitoring Team found – as it has in the past - that PMRs had good multidisciplinary examinations of the relevant clinical issues. • Integrated Morning Report: This was the daily meeting shared by many of the clinical disciplines and led by the Medical Director, to review day to day care as	Noncompliance

		it unfolded. The focus was medical care for individuals who lived at the Facility, whether it was provided on the campus or elsewhere, for example, one of the area hospitals. During the Integrated Morning Report attended by the Monitoring Team on 07/22/14 there were a number of references to somatic care challenges of individuals supported by psychiatry that helped explain behavioral health challenges. • Facility committees such as the P&TC, and the PRC were places where representatives of medicine, nursing, pharmacy, psychiatry, psychology and others came together to address matters related to medications. Since medications were key to many health care treatments, the coming together of many clinical disciplines around medication issues was a key part of Facility process. As outlined in Provisions J11 and J12, and in Section M of this report, the work done in those committees was an area of strength for the Facility. • Neurology – psychiatry integration: Since many anticonvulsant medications were used for both neurological and psychiatric problems, integration of information from the two disciplines was particularly important. Shared neurology and psychiatry conferences were held monthly. Please see Provision J15 for more information. • ISP meetings: The annual meeting of the entire IDT, to review and update the overall support plan of an individual; ISPs were observed by the Monitoring Team, per below During the current and past visit, the Monitoring Team witnessed a Facility process that was well focused on integrated care. For Provision J8 the particular focus remained on how combined assessment and case formulations were created and documented in a way that made them readily available to guide ongoing work of the IDT. A key place in the Facility process where that took place was the annual ISP meeting. During the visit an ISP meeting was held for Individual #280, one of the individuals included in Sample J1. The Monitoring Team observed that meeting. The meeting was inclusive and well run. At the Facility the individual has benefited from a well- constructed PBSP and from psychotropic medication. The behavior analyst and psychiatrist worked together very effectively to present an integrated summary of that care to the overall IDT and LAR. That work supported the creation of meaningful independent living goals for the Individual. Facility documentation of combined assessment and case formulation occurred in a number of places. At the level of the behavioral health team, documentation was in the IBHA, (see Provisions J3 and J9). At the level of the overall IDT, integrated care was documented in the PSP guide, IRRF, and IHCP. The Monitoring Team reviewed the IRRF and IHCP statement for the 20 individuals in Sample J1. IRRF statements about behavioral health include sections for (1) current supports, (2) current status, (3) proposed recommendations/rationale and (4) final recommendations/case	

		formulations. The last of these was written by the QIDP, after conclusion of the ISP meeting. In some cases, the key section on "final recommendation/case formulations" provided important information. For example: • Individual #671: *"Writing a PBSP to address aggression. Medications are important for that. Discontinuing Valium per psych med clinic. Mom indicates she does better with fewer medications and less "emergency medications." Stabilize on the Geodon and look into Risperdal in the future. (The client) can do just about anything but her behavioral issues are getting in the way with aggression and self-injurious behavior. If she did not have those, she could do a significant number of things and function independently in the community. The aggression and self-injurious behavior interfere, as well as the upcoming medication issues. She will need a special plan for medication administration per the psych med clinic note of (date provided). Doing chores in the home and other tasks to get her involved. Staff needs things to do to build a routine and that she can count on doing every day, and that can be faded out to more natural things. Focusing on what she can do will focus her away from behaviors.*" The suggestions for a program were consistent with comments made in the psychiatric and psychological assessments for the individual. • Individual #791: *"psychologist and psychiatrist will take time to figure out if Personality Disorder is part of his diagnosis or should be. However, his manipulating behavior makes it more difficult to determine what is real and what is for his plans. Charge nurse report explains that just because he does like direct support professional does not mean he should not take meds".* • Individual #*230: Psychiatric symptoms are stable and declining with 10 mg of Paxil, and looking at decreasing Paxil in the future. She will have a Psychiatric Support Plan, not a Behavior Support Plan. The plan will focus on her from her Psychiatric Support Plan with engaging in puzzles to manage environment to reduce anxiety, and to assist in preparing for adjusting in changes. Those will be included in her supports.* Unfortunately, only six of 20 (30%) IRRF statements provided information that provided integrated case formulation that supported a quality PSP. The remaining IRRF final recommendations contained either (1) information limited to a word or two about the behavioral care risk rating (e.g. "low," "moderate," etc.), (2) statements about restraint frequency, or (3) comments were missing/blank. The Monitoring Team discussed with the QIDP Coordinator the need for improvement. The QIDP Coordinator indicated that the matter will receive proper attention after the visit. <u>Monitoring Team's Compliance Rating:</u> There has been progress on this Provision. Integrated care at the level of the behavioral	

		team continues to improve with the increased use of the IBHA, but further improvement is needed to bring combined assessment and case formulation information into the ISP process. Accordingly, the Provision remains in non-compliance with the requirements of this provision.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	<u>Psychiatry Participation in PBSP and other IDT activities</u> To meet the requirements of this Provision, psychiatrists needed to be involved in the development of the treatment plan. The primary place where the clinical discussion took place was the PMR clinic, which was attended by the Psychiatrist, Psychologist, QIDP, Nurse Case Manager, and Direct Support Professional (DSP). At times, legally authorized representatives (LARs) and others also participated, 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. 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. Psychiatrists also participated in PMR 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. The particular requirements for Provision J9 were for assurances that the IDT: • Had determined the least intrusive and most positive interventions to treat the psychiatric condition were used • Had confirmed that medication treatment would also be accompanied by non-pharmacological support • Had assessed whether the individual was best served though behavioral, pharmacological or other interventions, in combination or alone The Monitoring Team reviewed the three required elements of the Provision by examination of the behavioral treatment program (IBHA/PBSP, Psychiatric Support Plan, or PBSP) of the 20 individuals in Sample J1. <u>That the least intrusive and most positive interventions to treat the psychiatric condition were used</u> IBHAs typically contained a section called "Behavioral Treatment History." BPSPs and Psychiatric Support Plans contained descriptions of "Attempts at Less Restrictive Practices." These reviewed current and past treatment and provided information to	Noncompliance

		assure that the IDT had considered the requirements cited above. Nineteen of 20 (95%) of the records contained the required determinations. <u>That medication treatment would also be accompanied by non-pharmacological support</u> All behavioral treatment programs for individuals in Sample J1 were for individuals who received pharmacological support. Eighteen of 20 (90%) had PBSP programs in place that provided the required non-pharmacological supports. Two individuals in the sample (Individuals #230 and #132) had Psychiatric Support Plans and did not have PBSPs. For further comments about Psychiatric Support Plans, see Provision J3. <u>Whether the individual was best served though behavioral, pharmacological or other interventions, in combination or alone</u> The Monitoring Team examined the records of the 20 individuals for information regarding which modalities of treatment--a PBSP, psychotropic medication, or perhaps evidence based treatments offered by other disciplines, for example occupational and physical therapies--were best suited to the individual and his/her needs. IBHAs contained several sections that addressed which treatments best suited the individual's needs. These included 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). Seventeen of twenty (85%) treatment plans contained some information about recommended modalities of treatment. For example: • Individual #474: *"Differentiation of function: The psychiatrist and psychologist agree in recommending that the behaviors of anxiety (crying, wringing hand, rocking, fearful response and avoidant behaviors) and compulsive behaviors (pacing, inability to cross lines or enter new spaces, repetitive behaviors or persistent rituals) are observable and measurable signs or symptom of GAD. Analysis of functional assessment information suggest that these behaviors are primarily a function of the psychiatric disorder and there appears to be no learned function. The primary treatment should be psychiatric with adjunctive behavioral hygiene support provided though the PBSP."* • Individual # 620*: "The individual's quality of life is dramatically impacted by the care she received in the current environment… Medication use is to continue on a maintenance basis and she will be monitored in the psych clinic on no less than a quarterly basis. Her strength and vulnerabilities are delineated in her PBSP to optimize the quality of her life."* • Individual # 373: *"Medication for psychiatric symptoms of mania, depression and insomnia. Carol will continue to have a formal PBSP to address maladaptive behaviors of physical aggression to others, verbally disruptive behaviors and stealing."* • Individual #151: "*Pharmacotherapy with Depakote and Geodon - both used as mood stabilizers to target symptoms of mood lability, impulsive aggression and*	

		agitation. Geodon is also used as an antipsychotic to target some recently reported psychotic symptoms such as responding to internal stimuli/talking to self. PBSP is implemented to minimize maladaptive behaviors such as aggression to persons and self-injurious behavior." • Individual #319: *"There has been a significant improvement in his behavior over the last few years, likely due to combination of environmental stability, effective psychotropic medications and PBSP. His medication has been simplified from five to two medications."* • Individual #488: "*Based upon the collective assessments from the Psychiatry and Behavioral Services Department (the Individual's) problem behaviors are a combined function of both his psychiatric disorder and learned behavior, under operant control. The treatment should be a combined treatment involving simultaneous psychiatric and behavior analytic interventions. The focus of … the PBSP should be on physical aggression toward others and episodic explosive behavior as observable manifestations of the Axis I disorders of Major Depressive Disorder and Alzheimer's dementia."* However, in the Psychiatric Support Plans for Individual #132, the psychiatrist reported on the benefits of the medication but also stated "(The individual) will continue to have a PBSP for target behaviors of physical aggression and verbally disruptive behavior." Given that statement it was not clear to the Monitoring Team why the Individual was placed on a Psychiatric Support Plan and/or why the PBSP was apparently discontinued. For additional comments on Psychiatric Support Plans, see Provision J3. <u>Monitoring Team's Compliance Rating:</u> There has been much progress on this Provision, facilitated by a well-structured IBHA structure that directed the psychologist and psychiatrist to address important matters of integrated care. Work remained to assure that all individuals who take psychotropic medication, including those assigned Psychiatric Support Plans, had appropriate non-pharmacological supports. In the Self-Assessment for this Provision the Facility wrote that although progress had occurred in many areas, there remained a need for improvement in the quality of documentation in psychiatric assessments, IBHAs, and ISP documents, in order to establish that treatment plans are developed after IDT collaboration about non-pharmacological treatment interventions or supports to minimize the need for psychotropic medications. The Monitoring Team concurred.	
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	<u>Policy and Procedure</u> 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 representative (LAR) must determine whether the harmful effects of the individual's mental illness outweigh	Substantial Compliance

	psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	the possible harmful effects of the medication, and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medication. This determination may occur in person or through telephonic communication, including during the psychiatric clinic, and the determination must be documented in person." <u>Processes in place for Risk Benefit Assessment</u> The place where discussions about medication (including risk/benefit analyses) typically took place was the PMR. PMRs took place on a monthly, quarterly, or as- needed basis. Interdisciplinary Team (IDT) participation in the clinics included psychiatrists, QIDPs, nurse case managers, psychologists and DSPs. 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. MPs were re-written annually as part of the annual review process, prior to the ISP. <u>Quality of the Risk Benefit Assessment</u> During the visit, the Monitoring Team observed discussions about risk and benefit during four PMRs. Prior to the observations, the Monitoring Team had reviewed records of PMRs held earlier in 2014. For Individual #230, Section IX of the PMR done on 05/09/14 stated the IDT reviewed the risks and benefits, and labs were reviewed. During the PMR for the individual observed by the Monitoring Team there was a review of those items and also substantive discussion about the benefit of the medication and the absence of any apparent difficulties. The MOSES examination was referenced and the results reviewed as part of the overall review. For Individual #132, the PMR of 3/26/14 included a review of labs, MOSES and QDRR. During the PMR attended by the Monitoring Team there was discussion of the taper and discontinuation of Aricept. There was an inquiry as to whether there were any rebound effects from the discontinuation, but there were none. Individual #411 had PMRs from 02/11/14 and 05/06/14 that contained statements about risk benefit reviews, side effect screens and labs, and there was also an active discussion of possible adverse effects including sedation, metabolic syndrome, and extrapyramidal side effects. Risk and benefit reviews were affirmed. Possible side effects and interactions between the psychotropics and anticonvulsants that the	

individual took were a focus during the PMR observed by the Monitoring Team along with the MOSES, QDRR, and lab reviews.

For Individual #488, the PMR of 2/3/14 documented MOSES, labs and QDRR reviews. The PMR documented IDT review of risks and benefits. During the PMR observed by the Monitoring Team there was an active discussion of possible causes of the falls the Individual had experienced and his general weakness. The team discussed their possible relationship to dementia. The psychiatrist commented on possible side effects and concluded these were not likely related to medication.

Documentation of Risk/ Benefit Assessment and Alternative Treatments for New Medications

Sample J3 contained all new medication plans reviewed by HRC during the review period. There were 24 new medications for 18 different individuals. Information provided about each new medication included (1) the most recent PMR note for IDT discussion, (2) 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, (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, and (4) documentation of HRC review of the new medication.

Treatment Alternatives

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 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 other therapies such as sensory integration therapy, sleep hygiene, and social skills training.

Results of the Monitoring Team's review of documentation was as follows:

Element	Information provided?	Monitoring Team's assessment of provided information
Psychiatric diagnosis for the medication (DSM format)	24 of 24(100%)	DSM diagnoses were presented for 24 of 24 (100%) medications
Rationale for the use of medication	24 of 24(100%)	Reasonable rationale was provided for 17 of 24

		(71%) of the medications
Psychiatric target symptoms for the treatment	24 of 24(100%)	Reasonable psychiatric symptoms for treatment were identified for 22 of 24 (92%) of the medications
Documentation of risk benefit discussion	24 of 24(100%)	Adequate presentation was provided for 22 of 24 (92%) of the medications
Documentation of nurse case manger participation in IDT deliberations	24 of 24(100%))	Adequate documentation was present for 24 of 24 (100%) medications
Documentation of participation of the PCP in IDT deliberations (typically via telephonic contact with the psychiatrist)	24 of 24(100%)	Documentation was ascertained via appropriate signature on consent form
Documentation of participation of the psychiatrist in IDT deliberations	24 of 24(100%)	Documentation was adequate for 24 of 24 (100%) of the medications
Documentation of specific medication side effects pertinent to the individual	24 of 24(100%)	Documentation adequate on 24 of 24 (100%) of medication plans
Documentation of possible alternative treatments	24 of 24 (100%)	Documentation was adequate for 24 of 24 (100%) of the medications

HRC Review of New Medications
Timely HRC review of the medications was provided as follows:

Individual #	Order Date	New Medication	HRC Review
10	5/7/14	Ativan	05/09/14
108	1/3/14	Latuda	01/08/14
108	4/28/14	Saphris	05/09/14
117	2/14/14	Neurontin	02/20/14
158	2/12/14	Lunesta	02/27/14
181	3/12/14	Doxepin	08/02/14
204	4/16/14	Abilify	04/24/14
204	5/19/14	Clonidine	05/22/14
222	5/6/14	Benadryl	05/09/14

		222	5/13/14	Unisom	05/22/14	
		319	1/24/14	Abilify	01/30/14	
		319	4/25/14	Zyprexa	04/30/14	
		335	4/7/14	Cytomel	04/17/14	
		388	3/14/14	Geodon	03/27/14	
		399	2/18/14	Ativan	03/05/14	
		474	1/2/14	Abilify 14	01/08/14	
		492	2/3/14	Seroquel	02/13/14	
		626	5/5/14	Seroquel	05/09/14	
		671	4/4/14	Tegretol	04/05/14	
		702	2/19/14	Ativan	03/05/14	
		702	2/28/14	Latuda	03/05/14	
		704	2/25/14	Seroquel	03/05/14	
		704	3/6/14	Zoloft	03/27/14	
		783	1/10/14	Zoloft	01/16/14	
		None of the medication trials were considered as emergency medications. Twenty-four of 24 (100%) medications were reviewed in a timely manner. For more details, see discussion under Provision J14. <u>Monitoring Team's Compliance Rating</u> 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. The Provision remained in substantial compliance.				
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	At the time of the compliance visit, 232 of 458 (51%) of the individuals who lived at the Facility received support from psychiatry, including psychotropic medication. Review of individuals who took psychotropic medication showed that 20 of 232 (8%) received two or more psychotropic medications from the same clinical class, e.g. two antipsychotics. This was considered to be psychiatric intraclass polypharmacy. Another form of psychiatric polypharmacy was when individuals received a total of three or more psychotropic medications; at the time of the visit 50 of 232 (21%) individuals who took medication received interclass polypharmacy.				Substantial Compliance

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.

Review of Polypharmacy Data:
For intraclass and interclass polypharmacy, the following data were provided by the Facility:

Reduction of Polypharmacy	Dec 2008	Dec 2009	Dec 2010	Dec 2011	Dec 2012	Dec 2013	June 2014
Prescribed Intraclass	24	21	18	12	16	17	20
Prescribed Psychotropic: 3 medications	56	53	50	46	51	55	55
Prescribed Psychotropic: 4 medications	34	26	17	15	10	11	11
Prescribed Psychotropic: 5 medications +	13	8	5	2	0	1	3

Continued reductions in polypharmacy – most evident in the number of individuals with four or more medications - were evident. In discussion with the Monitoring Team, the Facility noted that overall rates of polypharmacy have not increased during the year, despite the admission of several individuals who were treated with polypharmacy.

Processes in place for Facility Level Review of psychotropic medication use:
The Facility continued to use the PRC as the primary venue for polypharmacy reviews. The meeting of the PRC was attended by both psychiatrists and PCPs. The meetings were led by the Pharmacy Director. The structure of the meeting was that each month there was a review of all individuals with intraclass polypharmacy. The format for the review was that each psychiatrist reviewed the status of individuals under his/her care, and provided an update on the efforts to reduce the polypharmacy. These individual reviews included a summary of justification for the polypharmacy regimen and/or effort to reduce the polypharmacy. That was helpful since it established both the way that the Facility responded to the requirements of the provision and how appropriate medication practices were maintained. PRC reviews were pertinent not only to Provision J13, but also Provisions J3, J12, J13 and others.

In addition to reviews of intraclass polypharmacy, additional types of polypharmacy were also reviewed. For example, periodic reviews were held for individuals who had varying degrees of interclass polypharmacy (total of three psychoactive medications, four psychoactive medications, and so forth). Reviews were also focused on individuals

		who took certain classes of medications (benzodiazepines, anticonvulsants, anticholinergics and so forth). Use of anticholinergics and medications for cognitive decline were also reviewed. The monthly meetings were well structured and meetings were well attended. The overall discussion that was documented in the PRC discussion contributed meaningfully to integrated care. P&TC meetings reviewed many issues that were related to medication and polypharmacy use. For example, the P&TC meeting for January 2014 included a detailed review of Facility policy for the use of Clozaril, an effective antipsychotic that nonetheless requires careful monitoring for metabolic, hematological, and immunological side effects. The review included Facility-wide data (for example, the percentage of individuals who had the required waist measurement in place). The review was on ways that laboratory abnormalities were identified and corrected, for individuals who took Clozaril. <u>Monitoring Team's Compliance Rating</u> Overall, the Monitoring Team found that review of polypharmacy continued to be detailed and substantive, at the individual level via the QDRR, in discussion that followed in the PMR, and in the monthly reviews described above. The Provision remains in substantial compliance with the requirements of the SA.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	<u>Policy and Procedure:</u> DADS Policy 007.3 Psychiatric Services (05/01/2103) addressed the matter of side effect screening. The policy clarified that the nursing staff must pass competency based training annually prior to completing the DISCUS and MOSES evaluations, that 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 the side effect screen may also be done within 30 days of a medication dose change, as determined clinically necessary by the psychiatrist. <u>Process in Place for Side Effect Screening</u> MOSES examinations were done by each individual's nurse case manager. The nurse case manager then presented the forms for review and signature to the psychiatrist (for the DISCUS) or psychiatrist and PCP (for the MOSES). MOSES and/or DISCUS examinations were also done following a psychotropic medication change, as determined clinically necessary by the psychiatrist. Side effect screens were also reviewed during PMRs and were part of the data from other IDT activities such as the ISP meeting, IRRF evaluations and neuropsychiatry reviews. Facility-wide reviews took place at PRC. <u>Individual Case Reviews - MOSES and DISCUS Examinations</u> Routine MOSES screenings were required every six months, with additional screens to be as clinically appropriate with changes of medication dose. MOSES reviews were provided	Substantial Compliance

		for 20 of 20 (100%) individuals in Sample J1. A total of 50 reviews were done for those individuals. Every individual had a least two screenings, and some had more. The average number of screenings during the review period was 2.5 per individual. The forms indicated the reason for the screening. Typically, there was either a scheduled review or an additional screening done due to a change in medication dose. In all cases the screen was reviewed in a timely manner and the physician review section was completed and signed. Routine DISCUS screenings were required every three months for individuals who took medications that can cause tardive dyskinesia. Additional screens were done as clinically appropriate with changes in medication doses. Fifteen of 20 (75%) individuals in Sample J1 were given medications that can cause tardive dyskinesia, and all 15 (100%) received at least two screenings. The total number of screens done for the 15 individuals was 35 for an average of 2.33 for each individual. The forms indicated the reason for the screening and the additional screening were done due to a change in medication dose. In all cases the screen was reviewed in a timely manner and the physician review section was completed and signed. As described for Provision N.5 of this report, the Monitoring Team requested all MOSES and DISCUS assessments that were completed during this review period, for individuals who were prescribed a new neuroleptic and who neuroleptic dose was decreased or discontinued, and was provide a total of 27 MOSES, and 33 DISCUS assessments for individuals #580, #666, #251, #18, #131, #371, #774, #702, #388, and #703. For the ten examples that indicated a change in neuroleptic dose, eight out of ten (80%) indicated more frequent side effect monitoring by MOSES and DISCUS. Upon review of DISCUS assessments that indicated a diagnosis of TD, the Monitoring Team was concerned over the appropriateness of the completion of the DISCUS assessment. For example: • Individual #131: o DISCUS 1/22/2014: Total score was rated as five, however, the evaluation indicated a total score less than five. o DISCUS 2/24/2014: Total score was rated as five, and the evaluation component indicated a total score of less than five. Also, the DISCUS reported that the 1/24/2014 DISCUS was rated as a five. The Monitoring Team was provided a 1/22/2014 DISCUS, which was rated as a five. o DISCUS 4/11/2014: Total score was rated as five, and the evaluation component indicated a total score of less than five; also indicated that the DISCUS score from 2/24/2014 was four, when it was rated as a five. o DISCUS 6/18/2014: Total score was rated as five, and the evaluation component indicated a total score of less than five; also indicated that	

		the DISCUS score from 4/11/2014 was four, when it was rated as a five. o For all DISCUS assessments provided for this Individual, the evaluation component did not indicate if there was, or was not a component of an underlying diagnosis, other than medication related. • Individual #702: o DISCUS 1/17/2014 indicated a total score of one, and the physician documented under the comment section "improved speech, others able to understand (the individual's) speech better since last medication change; continue to have some amount of ESP movements as previous evaluation. No change noted". The DISCUS assessments dated 2/18/2014, and 2/21/2014 indicated a total DISCUS score of five. The evaluation section indicated that the total score was less than five, and the physician did not document this significant change under the comment section, in fact, the physician documented the exact same statements as documented on the 1/17/2014 DISCUS assessment. o The DISCUS assessments dated 2/27/2014, 3/5/2014, 4/2/2014, and 4/30/2014 indicated a total score of 5; however, the evaluation component indicated that the score was less than five; furthermore, the physician did not document under the comment section, despite persistent TD. The physician should briefly indicate the cause of the TD, and clinical plan. o For all DISCUS assessments provided for this Individual, the evaluation component did not indicate if there was, or was not a component of an underlying diagnosis, other than medication related. <u>Facility- level review of Individuals who had Tardive Dyskinesia</u> 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 47, #117, #131, #244, #311, #363, #399, #486, #531, #702, #704, #743, and #774. Active Problem Lists (APLs) were provided and 12 of 13 (92%) individuals had that diagnosis on the APL. PRC meeting minutes confirmed that the review of all individuals who had dyskinesia was done as part of the work of the PRC. <u>DISCUS Monitoring for Individuals taking Metoclopramide</u> 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 27 individuals at the Facility who took metoclopramide. Facility nursing tracking sheets showed that DISCUS screenings were provided for those individuals every three months. None rated positive for dyskinesia.	

		Training for Administration of the MOSES and DISCUS side effect screens: 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 attended training as part of their orientation and the annual re-training on the administration of the side effect tools. Annual refresher training for MOSES and DISCUS administration was provided in Jan 2014. At the time of the visit there were 27 nurse case managers. Twenty-five had been at the Facility for over a year and they attended the Jan 2014 annual training. Three nurses had been hired since then and those nurses had attended training during their orientation. Monitoring for Metabolic Syndrome Unlike the DISCUS examination for tardive dyskinesia, there is no standard assessment tool for monitoring, detecting, reporting and responding to the presence of metabolic syndrome, a condition that involves changes in weight/abdominal girth, 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 Individuals #132, #230, #411, and #488 and noted that metabolic syndrome screening was reviewed in 3 of 4 (75%) PMRs. Metabolic syndrome monitoring was also a focus for Facility-wide PRC reviews. Monitoring Team compliance ratings: 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.	

		Per the last compliance report, dated 3/19/2014, the Monitoring Team was concerned that the Facility did not ensure more frequent monitoring for TD following the change in dose of a neuroleptic. During this compliance period, 80% of the examples reviewed demonstrated more frequent monitoring for TD following a change in neuroleptic dose. Therefore, this provision is found in substantial compliance. However, there was one area of decline that must be addressed to retain compliance. The Facility must enhance completion of the evaluation, and physician component of the DISCUS assessments.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	<u>Facility Procedure</u> Psychiatrists wrote a MP each time a new psychotropic medication was proposed. In addition, MPs for existing psychotropic medications were reviewed and updated as part of the annual psychiatric updates that were completed prior to annual ISP meetings. The sections of the MP remained: • Name of the medication • Psychiatric Diagnosis • Rationale for Treatment • Psychiatric Target Symptoms • Monitoring for Efficacy (by whom, where and how often) • Timeline for Expected Results • Risk/Benefit Assessment • Treatment Alternatives The Monitoring Team confirmed that Medication plans were in place for 20 of 20 (100%) individuals in Sample J1. <u>Monitoring for Treatment Efficacy</u> Individuals' treatment plans (IBHA/PBSP, PBSP, and Psychiatric Support Plan) contained the details of the individual's medications and how they were tracked for efficacy. For each individual the IBHA listed • Psychiatric treatment "targets" • Operational definitions of those behavioral targets • Clarification of the rating of severity used by the Facility's ratings (typically, a Likert style scale of 1-3) The Monitoring Team reviewed data for efforts to track medication efficacy for the twenty individuals in Sample J1. The individuals' records provided psychiatric treatment targets for 20 of 20 (100%) individuals, operational definitions were provided for the selected targets for 16 of 20 (80%) individuals, and severity criteria for ratings were provided for 16 of 20 (80%) individuals. Graphs with data were provided for 15 of 20 (75%) individuals. In most cases the selected targets were appropriate for psychiatric monitoring and the operational definitions were good. However, during previous visits	Noncompliance

		the Monitoring Team had emphasized the need for at least one of the targets for the medication to be linked in a meaningful way to the underlying psychiatric diagnosis. That was needed to assure that the medication was not being used purely for behavioral control. Some more work needed to be done on that matter. For example, for Individual #671 the only tracking was for various forms of aggression. Monitoring for treatment efficacy took place at the PMR reviews during which current data was presented to the psychiatrist along with other psychiatric behavioral and medical data. The number of targets for individuals ranged from one to five. Data for medication tracking was typically presented as a single graph that contained multiple lines that corresponded to the various psychiatric "targets". A second graph that recorded data collected by psychologists for general behavioral targets that were not directly linked to medications was also presented. The two graphs were typically charted on the same page, to allow comparison of similarities or differences between behavioral and psychiatric data. That was useful, since it provided information needed to compare medication and non-medication treatment efficacy. Comparison of the two graphs could also help examine whether there is good differentiation of function between psychological and psychiatric "targets." During review of data sources for treatment efficacy monitoring, the Monitoring Team noted that in some cases, different medication "targets" were listed for a given medication in different places. For example there were sometimes differences between the medication treatment plan, the IBHA citation of the treatment plan, and the targets listed on the form for PMR reviews. This was the case for Individual #230, one of the individuals for whom a PMR took place during the visit. That provided an opportunity to explore how the problem came about. It emerged that the psychologist supporting the individual was newly assigned to his IDT. When the psychologist joined the IDT for Individual #230, she took guidance about tracking needs from the prior PMR's and not from the IBHA. She also consulted with other IDT members and concluded that one of the agreed upon measures was no longer meaningful. However, she did not consult the individual's behavioral treatment plan, nor did she update it. During the visit the Monitoring Team discussed with the Facility the need for an agreed upon reference source for medication tracking "targets" and related information. The source could be the individual's IBHA, or perhaps a departmental database. Once a Facility procedure is in place, it will also be necessary to establish ways for the source to be updated as clinical circumstances change. <u>Monitoring Team's Compliance Rating</u> Overall, the Facility has made tremendous progress toward developing practical and clinically meaningful methodologies to provide the psychiatrist with appropriate data that can inform subsequent decisions on medication management. Further work is needed to insure that appropriate targets are selected for each medication, and that	

		systems are in place to maintain the ongoing flow of information. Overall, the Facility is close to achieving substantial compliance for this key provision.	
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> 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." <u>Consent Form in Place at the Facility</u> The consent form currently in use at the Facility provided the following information: • Diagnosis • Medication for approval, medication dose, and route of administration • FDA recommended dose range • Pertinent side effects 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. A general indication was provided on the form in which the (LAR) acknowledged that explanations about the medication were given in simple, nontechnical language and included: • A description of any benefits to be expected • Disclosure of any appropriate alternative procedures that might be advantageous to the person served as well as the potential risks and benefits associated with those alternatives • Possible adverse side effects/risk of the prescribed medication, per drug effect monographs provided <u>Medication Plans provided to LARs</u>	Substantial Compliance

		LARs were provided with a copy of the MP that contained considerable information about the medication including information on: • Name of the medication • Psychiatric Diagnosis • Rationale for treatment • Target psychiatric symptoms • Monitoring for Efficacy (by whom, where and how often) • Timeline for expected results • Risk/Benefit Assessment • Treatment Alternatives Detailed analysis of the quality of the Medication Plans is provided under Provision J10. <u>HRC Review of Consent</u> The Facility used a revised (effective 3/22/13) form for HRC review of psychotropic medication. The form provided check boxes for • Psychiatric case formulation and treatment plan • Psychotropic medication plan • Psychotropic medication consent form • Most recent PBSP These boxes identified the information that was provided to the HRC for medication review and approval. <u>Monitoring Team Review</u> To assess compliance during the overall review period the Monitoring Team requested all non-emergency psychotropic medications started since the last visit. That was Sample J3 and consisted of 24 medications for 18 individuals. Presentation of information about the medication continued to improve and the MPs followed the above presentation of information per 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 reviewed medication consents and HRC review for the 18 individuals in Sample J1. Consents were provided for all psychotropic medications and timely HRC review was provided for 24 of 24 (100%) medications. <u>Monitoring Team's Compliance Rating</u>	

		Informed consent and HRC review of consent was obtained for all new medications and the provision remains in Substantial Compliance.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Materials reviewed for assurance of compliance with Provision J15 included a review of dual purpose anticonvulsant medications used (1) for psychiatric indications, (2) for neurological indications, and (3) dual purpose medications used for both psychiatric and neurological indications. The Monitoring Team reviewed the ongoing functions of the neurology-psychiatry clinic with the nurse who coordinated the neurology clinic. No neurology-psychiatry clinic was scheduled during the visit of the Monitoring Team, so the clinic could not be observed. The Monitoring Team learned that the clinics continued to be held monthly, at the beginning of one of the scheduled on-site neurology clinics. The conference length varied but was typically about an hour. It was attended by the neurologist, one of the psychiatrists, the neurology clinic coordinator, and one of the psychiatry assistants. In addition to participation in the designated neurology-psychiatry clinic, psychiatrists were free to consult with the neurologist on an as-needed basis during any given neurology clinic, and the Monitoring Team was informed that they did so. The Monitoring Team requested and was provided with the most recent notes for five individuals who were seen in both the psychiatry and neurology clinics and were medicated with an anticonvulsant. Individuals #64, #319, #533, #557, and #766 were selected. Individuals #64, #319, #533, #577, and #766 were treated with anticonvulsants for a neurological and also a psychiatric disorder. In each case the notes from the two clinics showed awareness of the reasons that the medication was used. Review of clinic notes showed that: • Individual #64 was stable and was monitored on an ongoing basis with Depakote for both mood lability and epilepsy. The notes reflected routine monitoring of treatment with appropriate labs and clinical examinations. • Individual #319 was diagnosed with epilepsy and autism. The individual had been seizure-free for a prolonged period but had experienced a recurrence of the seizures. Note from the neurology and psychiatry clinics showed that there was a good dialogue between the neurologist and psychiatrist regarding the selection of Depakote as the anticonvulsant and the monitoring of the drug for serum levels, other labs, and neurological and behavioral effects. • Individual #533 was diagnosed with intermittent explosive disorder and a seizure disorder. He also had cerebral palsy and a hemeparesis. During the review period the dual purpose medication was in the process of change from	Substantial Compliance

		Tegretol to Depakote. The clinic notes documented good discussion between the neurologist and psychiatrist about drug levels and the efficacy of treatment. • Individual #557 represented collaboration between neurology and psychiatry, although not epilepsy. The Individual was diagnosed with a tremor that could have represented a medication side effect. The psychiatrist requested consultation from the neurologist about the tremor and the two physicians collaborated on the diagnosis and the plan for treatment. • Individual #766 was treated with carbamazepine/oxcarbamazepine for psychiatric purposes but due to breakthrough seizures the neurologist increased the dose so that it would help with seizure management. There was good communication from the neurologist about his new use of the medication for dual purpose. <u>Monitoring Team's Compliance Rating</u> On the basis of the discussion with the psychiatrists, the discussion with the clinic coordinator, and review of the relevant documents, the Monitoring Team found that coordination between psychiatry and neurology remained strong, and DSSLC remained in compliance with the provision of the SA.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment (7/3/2014) 2. DSSLC Action Plan (Undated) 3. DSSLC Presentation Book for Section K (7/25/2013) 4. Positive Behavior Support Committee meeting minutes 1/2/2014 – 5/28/2014 5. Documents that were frequently reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), Integrated Behavioral Healthcare Assessments/Positive Behavior Support Plans (IBHA/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. All document reviews were conducted in the context of the Self-Assessment. a. The review of data monitoring practices in K.4 included Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. b. The review of Psychological Assessment reports in K.5 included Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. c. The review of SFAs concerning assessment of behavior in K.5 included Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. d. The review of SFAs in the context of the integration of mental illness and behavior assessment in K.5 included Individuals #91, #333, #459, #475, #542, #612, #671, #673, and #765. e. The review of psychological testing and evaluation reports for individuals admitted to the Facility since the previous site visit presented in K.7 included Individuals #7, #142, #162, #180, #256, #268, #436, #456, #477, #513, #542, #584, #586, #671, and #744. f. The review of IBHA/PBSPs in K.9 included Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. g. The review of data graphs in K.10 included Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. **People Interviewed:** 1. Trenton Berrie, MS, BCBA – Interim Director of Behavior Services 2. Katy Acheson, MS, BCBA – Contract Psychologist 3. Laura Dittlinger-Harper, BCBA - Consultant 4. Approximately 25 direct support professionals in the following residences: #522D, #522B, #523B, #523D, #525C, #525A, #525B, #526A, #526D, #508A, #508C, #527A, #527D, and #505B **Meeting Attended/Observations:** 1. Positive Behavior Support Committee 2. Human Rights Committee 3. The following residences and day treatment areas: #522D, #522B, #523B, #523D, #525C, #525A,

	#525B, #526A, #526D, #508A, #508C, #527A, #527D, and #505B
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. At the time of the site visit, DSSLC reported in the Self-Assessment that Provisions K.2, K.3, K.8, and K.11 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. In addition, the Monitoring Team found the Facility to be in Substantial Compliance with Provision K.9. For Section K, in conducting its self-assessment: ▪ The Facility did report the use monitoring/auditing tools. The Facility did report the materials or procedures that were reviewed, often with substantial detail. The Self-Assessment did not, however, indicate the tools used in the monitoring/auditing process. ▪ The Facility did use other relevant data sources, such as BCBA certification tracking information, internal and external peer review results, individual All About Me books, IBHA/PBSP data sheets, assessment tracking data, and staff training summaries, ▪ The Facility did present information about all provisions. Without clear indications of what tools and procedures were used, it was at times difficult to determine the utility or accuracy of the information. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as Complete, In Process, and Not Started. No particular patterns were noted in the status of elements. ▪ The Facility data identified areas of need/improvement. In many circumstances, however, the Action Plans did not indicate the specific actions to be taken. In addition, the action steps focused upon establishing processes or developing tools rather than focusing upon qualitative enhancements.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at DSSLC from 7/21/2014 through 7/25/2014. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that that the Facility had built upon previous achievements and continued to make progress; at times, that progress was considerable. It also appeared that the Facility was working toward substantial compliance in a systematic and coherent manner. Although an extensive amount of work remained, it was suggested that current processes were effective. Although several areas continued to lack substantial compliance, there were areas where notable progress had been achieved. • The Facility had maintained 100% of staff either possessing or working toward behavior analyst board certification.

	• The Facility continued to employ an adequately credentialed director of psychological services. • The Facility continued to utilize a comprehensive internal and external peer review process. • The majority of IBHA/PBSPs were based upon comprehensive behavior assessments. • The Facility continued to maintain an exemplary process for development and implementing counseling services. • The majority of IBHA/PBSPs were comprehensive and met current standards of practice. • Other than reliability and treatment integrity data, behavior data graphs were clear, comprehensive, and reflected all essential components.. Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • Reviews reflected that only 60% of IBHA/PBSPs were completed by a BCBA • The monitoring of behavior intervention effects continued to reflect weaknesses, such as a lack of BCBA review of progress and inconsistent measurement of reliability and treatment integrity. • The Facility was unable to provide consistent and timely assessment of intellectual ability and adaptive skills. • Very few IBHA/PBSPs completed by DSSLC adequately differentiated between behavior and mental illness targets, and did not integrate behavior and psychiatric interventions. • Individuals recently admitted to the Facility often were not provided with assessments of intellectual ability and adaptive skills within 30 days of admission. Although Section K was not found to be in substantial compliance, the Facility should be commended for the continued effort toward satisfying the requirements of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
K1	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	Current Site Visit During the current site visit, Facility records regarding Behavior Support Department staff were reviewed. These records reflected that seven of 16 staff (44%) were board certified as a behavior analyst. Of the remaining nine staff, nine (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.	Noncompliance

	Baseline	1/2014	7/2014
Percent of staff who were BCBAs	24%	60%	44%
Percent of staff lacking BCBA who were pursuing board certification	23%	40%	56%
Percent of staff who were BCBAs or were pursuing board certification	50%	100%	100%

#	Provision	Assessment of Status	Compliance
	reasonable safety, security, and freedom from undue use of restraint.	DSSLC maintained a process for auditing credentials of those staff members who possess board certification in applied behavior analysis. During the current site visit, the Monitoring Team used a sample of 10 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 #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. Based upon the information provided from the review, six of 10 behavior intervention plans (60%) were completed by a BCBA. The Facility demonstrated continued effort 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.	
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 facility currently employs a Director of Psychology. The previous director, Randy Spence, MS, BCBA, retired in February 2014. The Facility had appointed an interim director at the time of the current site visit, Trenton Berry, MS. Mr. Berrie had been employed at DSSLC since 2009, and was a board certified behavior analyst. As a BCBA, Mr. Berrie satisfied the Provision K2 requirements for substantial compliance with the Settlement Agreement.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	DSSLC, at the time of the current site visit, continued to implement the internal and external peer review process noted during previous visits. The internal peer review committee was coordinated by the Behavioral Services staff members who are board certified as behavior analysts. A review of committee minutes and discussions with staff revealed active application of a peer review model that was sound and met expectations. Based upon information obtained during the current site visit, the Facility remained in substantial compliance with Provision K.3.	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	<u>Historical Perspective</u> 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 IBHA/PBSP. In February of 2011, a new data collection system was implemented that used a standard form for recording data. This form was designed to accommodate frequency counts, as	Noncompliace

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.</td><td>well as duration, interval and accuracy measures. In September 2011, observations and record reviews revealed substantial improvement, although substantial limitations continued.

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.

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.

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. In January 2014, however, information suggested treatment data were not 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.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team used a sample of 10 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 #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765.

The table below reflects the results from the current site visit review regarding the collection and presentation of data.

<table>
<tr><td></td><td>Baseline</td><td>1/2014</td><td>7/2014</td></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>79%</td><td>90%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>71%</td><td>90%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>71%</td><td>50%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>93%</td><td>90%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>60%</td><td>64%</td><td>100%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Replacement behaviors graphed sufficient for decision-making	0%	71%	100%

The information obtained during the site visit reflected substantial improvements in four of six areas (67%) Declines were noted in two of six areas (33%), although in one area the decline was only 3%. The only item that did not meet the criteria for substantial compliance involved inadequate inter-rater reliability. In half the reviewed records, reliability was either not reported or remained well below 80% agreement for two or more consecutive observations without evidence of revision of definitions.

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.

	Baseline	1/2014	7/2014
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	100%	80%
Review is conducted by a BCBA	0%	50%	50%
Input from direct care staff is solicited and documented	0%	29%	60%
Modifications to the IBHA/PBSP reflect data-based decisions	0%	64%	70%
Criteria for revision are included in the IBHA/PBSP	0%	100%	100%
Progress evident, or program modified in timely manner (3 Months)	0%	64%	70%

Based upon available data, it was determined that the Facility had maintained previous ratings in two areas (33%), had regressed in one area (17%), and had progressed in three areas (50%). Five of the six areas did not meet criteria for substantial compliance. Noted weaknesses and concerns included the following.

- The monthly review of treatment data and progress notes involved a BCBA in only five of the 10 reviewed records (50%).
- Input from direct care staff was presented in progress notes for six of the 10 records (60%). This was an improvement over previous visits, but four of 10 records (40%) either included no section for reporting staff input or had no information in that section of the progress note.
- Modifications to the IBHA/PBSP reflected data-based decisions in seven of 10 records (70%).

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
Progress notes for three of 10 behavior intervention programs (30%) were noted to reflect worsening behavior or other problems without a timely response from the program author or IDT.
Based upon the available information, it was noted that despite some improvement the Facility was unable to ensure that treatment data were recorded correctly and consistently. Furthermore, it was not clear that treatment decisions were evidence-based. As a result, the Facility was found to have not met the criteria for substantial compliance.
</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td>
<u>Historical Perspective</u>
Through the September 2011 site visit, DSSLC had demonstrated minimal changes in the provision of testing of intellectual ability and adaptive skills in comparison with the baseline site visit; The September 2011 sample reflected that there was 0% compliance. In April of 2012, the Facility demonstrated a substantial increase in the number of Psychological Assessment reports. None of the reports reviewed, however, included current assessments of intellectual ability or adaptive skills. In October 2012, issues with documentation prevented an assessment of the Psychological Evaluation reports and the testing of intellectual ability and adaptive skills. 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. The review in January 2014 revealed several regressions concerning the provision of intelligence and adaptive skill assessments.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team used a sample of 10 individuals for the review of psychological assessments. The Facility selected the sample from individuals with recent ISPs. The specific individuals included in the sample were Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765.
<table>
<tr><th></th><th>Baseline</th><th>1/2014</th><th>7/2014</th></tr>
<tr><td>A Psychological Assessment had been completed.</td><td>0%</td><td>71%</td><td>80%</td></tr>
<tr><td>The Psychological Assessment was less than one year old</td><td>0%</td><td>71%</td><td>80%</td></tr>
<tr><td>The Psychological Assessment contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>14%</td><td>30%</td></tr>
<tr><td>The Psychological Assessments contained findings of adaptive assessment conducted</td><td>9%</td><td>71%</td><td>30%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

within one year prior to the date of the Psychological Assessment.			

Based upon the findings of the review, it was apparent that DSSLC had made only slight progress in ensuring that Psychological Evaluation reports were completed in a timely manner. Although some progress was noted in intellectual assessments, a substantial decline was noted in the provision of timely adaptive skill assessments. In the sample of 10 individuals, the following issues or weaknesses were noted.

- Only three of 10 individuals (30%) had been provided with a current adaptive skill assessment. This reflected a decrease of 57% in comparison with the previous site visit.
- Three of 10 individuals (30%) had been provided with a current assessment of intelligence. Although better than the previous site visit, this reflected far less than an adequate provision of assessments.

The Facility also provided global data regarding psychological assessment reports. A review of those data reflected the following issues.

- Sixty-eight of 460 individuals (15%) were not reported to have a psychological assessment report in the previous year.
- The Facility did not maintain tracking information concerning dates of intellectual and adaptive skill testing.

Based upon information obtained from the Facility, it appeared that several limitations existed concerning Psychological Evaluation reports and the testing of individual abilities.

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

#	Provision	Assessment of Status	Compliance
		Historical Perspective 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 IBHA/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. In January 2014, data revealed the Facility was often able to conduct thorough and sophisticated assessments of behavior. There were instances that raised questions, however, about how well the case formulations of mental illness and interventions were integrated. Current Site Visit During the current site visit, the Monitoring Team used a sample of 10 individuals for the review of behavior assessments. The Facility selected the sample from individuals with recent ISPs. The specific individuals included in the sample were Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765.	

	Baseline	1/2014	7/2014
Assessment or review of biological, physical, and medical status	0%	86%	100%
Review of personal history	0%	86%	100%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	64%	80%
The process or tool utilizes both direct and indirect measures	0%	64%	80%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	64%	80%
Identification of antecedents relevant to the undesired behavior	0%	64%	80%
Identification of consequences relevant to the undesired behavior	0%	64%	90%
Identification of functions relevant to the undesired behavior	0%	57%	80%
Summary statement identifying the variable or variables maintaining the target behavior	0%	64%	80%
Identification of functionally equivalent replacement behaviors relevant to the	0%	57%	90%

#	Provision	Assessment of Status	Compliance

undesired behavior			
Identification of preferences and reinforcers	0%	71%	70%

The information obtained during the site visit reflected substantial improvements in 10 of 11 areas (91%) Declines were noted in none of 10 areas (0%), and performance remained essentially unchanged in one of 11 areas (9%). The only item that did not meet the criteria for substantial compliance involved preference assessments.

During the current site visit, a sample of nine records was used to assess the integration of mental illness and behavior assessments. This sample was the same as reported immediately above, minus Individual #507 who was not diagnosed with any mental illness. The findings of the review are presented in the table below.

	Baseline	1/2014	7/2014
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	92%	80%
The assessment process included differentiation between learned and biologically based behaviors.	0%	33%	33%
Identification of behavioral indices of psychopathology	0%	33%	11%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	83%	0%

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.

- For Individual #91, one mental illness symptom identified as a psychiatric target in progress notes was spitting. Spitting, however, was not presented in the psychiatric case formulation. Neither was it included in the structural/functional assessment even though changes in spitting frequency were not correlated with changes in psychotropic drugs or drug dosages. It therefore was suggested that there was little integration between the psychiatrist and behavior analyst in

#	Provision	Assessment of Status	Compliance
		assessing problems, assigning targets, and tracking the individual's response to treatment. • For Individual #333, the psychiatric case formulation emphasizes ritualized behavior and poor socialization as problems for the individual. Despite this, psychotropic medications targeted physical aggression and agitation. The structural/functional assessment indicated that physical aggression and agitation were primarily under the control of environmental factors and operant contingencies. In addition, data revealed that physical aggression and agitation improved in response to a residence change and the implementation of a IBHA/PBSP rather than to psychotropic drug changes. Documentation did not reflect any attempt to address the discrepancy between behavior assessments and the psychiatric case formulation. There was also evidence of inadequate integration of behavioral and psychiatric interventions beyond the sample of 10 individuals. One such example involved Individual #457 who had been recently discharged to the community. Records revealed this individual was diagnosed with autism and profound intellectual disability, and had an extensive history of self-injury, rumination, pica, sleep disturbance, yelling, and running from staff. The Integrated Behavioral Health Assessment, completed shortly before discharge, contained several weaknesses that reflected inadequate assessment and potentially impaired the provision of correct and beneficial intervention. • Although the individual was prescribed three psychotropic medications, the Psychiatric Case Formulation lacked specific justification for those medications. Targets presented for Risperdal and Depakote included mood lability, impulsivity, aggression, irritability and anxiety. The individual, however, was not diagnosed with a mood disorder, and none of those targets was being tracked as a part of intervention monitoring. • The psychiatrist indicated that the tracked targets (running from staff and yelling) were not functional and of sufficient severity to warrant psychotropic medication. Behavior data, however, suggested a strong relation between behavior interventions and the frequency of yelling and running from staff. • Despite data reflecting a relation between the behavior intervention and the psychiatric targets of yelling and running, these two targets had not been subjected to a structural/functional assessment. Similarly, two behaviors included in the Axis III diagnosis, rumination and pica, were not subjected to structural/functional assessment. • Concerning the self-injury, the function presented in the Determination of Function and Environmental Relation was automatic negative reinforcement in the form of pain attenuation. Anecdotal functional assessments, however, revealed a function of positive reinforcement via obtaining tangibles, while some	

#	Provision	Assessment of Status	Compliance
		staff reported evidence of escape from attention as a maintaining function. These discrepancies were not discussed or addressed through additional assessments. Overall, the Integrated Behavioral Health Assessment failed to develop and present a coherent assessment process or an integrated, evidence-based intervention strategy. Despite considerable progress in some provisions, information obtained during the current site visit suggested that the Facility continued to experience considerable difficulty in some areas. In order to obtain substantial compliance, it will be necessary for the Facility to implement substantive changes in relation to psychological evaluation assessments, as well as the integration of behavioral and psychiatric assessments and intervention.	
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. • Sixty-eight of 460 individuals (15%) were not reported to have a psychological assessment report within the previous year. • The Facility did not maintain tracking information concerning dates of intellectual and adaptive skill testing. 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 Facility pursuant to the Facility's standard psychological assessment procedures.	Information provided to the Monitoring Team prior to the site visit reflected that 15 individuals were admitted to the Facility since the previous site visit, Individuals #7, #142, #162, #180, #256, #268, #436, #456, #477, #513, #542, #584, #586, #671, and #744. The Facility did not maintain tracking records for testing. The Facility did provide written reports for all 15 recently admitted individuals. Based upon the submitted reports, the following circumstances were noted. • Three of 15 recently admitted individuals (20%) were provided with adaptive skill assessments within 30 days of admission. • Seven of 15 recently admitted individuals (47%) were provided with intellectual assessments within 30 days of admission. • Eleven of 15 recently admitted individuals (73%) were provided with behavior assessments within 30 days of admission. • Fourteen of 15 recently admitted individuals (93%) were provided with psychological assessment reports within 30 days of admission.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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><u>Current Site Visit</u>
At the time of the current site visit, 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, #410, #459, #483, #531, #542, #629, and #781. The table below presents information obtained from the review of the 10 records.
<table>
<tr><th></th><th>Baseline</th><th>1/2014</th><th>7/2014</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 number of sessions without meeting the learning goal that will trigger review and revision of intervention</td><td>0%</td><td>100%</td><td>90%</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>
</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>Service identified in ISP and, if applicable, IBHA/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>

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 IBHA/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. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>
<u>IBHA/PBSP Approval and Consent</u>
DSSLC reported that 223 IBHA/PBSPs had been implemented since the previous site visit. Out of those 223 IBHA/PBSPs, five (2%) were implemented prior to the Human Rights Committee review and four (2%) had been reviewed by the Human Rights Committee.

A review of Facility tracking data reflected that the Facility had demonstrated considerable improvement in implementing IBHA/PBSPs promptly after approval and consent were obtained. For 33 of 223 IBHA/PBSPs completed since the previous site visit (15%), there was a delay of greater than 14 days between consent and implementation. During the previous site visit, 29% of IBHA/PBSPs reflected a delay of greater than 14 days. The average noted delay during the current site visit was 10.99 days.

<u>IBHA/PBSP Review</u>
During the current site visit, the Monitoring Team selected a sample of 10 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 #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765.

<table>
<tr><td>IBHA/PBSP Element</td><td>Baseline</td><td>1/2014</td><td>7/2014</td></tr>
<tr><td>Rationale for selection of the proposed</td><td>50%</td><td>79%</td><td>100%</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

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

Based upon available data, it was determined that the Facility had maintained previous ratings in two areas (12%), had regressed in no areas (0%), and had progressed in 15 areas (88%). Sixteen of the 17 areas (94%) met criteria for substantial compliance. It was therefore suggested that DSSLC had met the expectations of substantial compliance for this provision.

K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding	<u>Historical Perspective</u> 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.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td>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.

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. During the January 2014 site visit, however, modest declines were noted in the quality of graphed data.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, behavior interventions, or psychotropic medication reviews. The specific individuals included in the sample were Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765.

<table>
<tr><th>Graph Element</th><th>Baseline</th><th>1/2014</th><th>7/2014</th></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>100%</td><td>64%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>0%</td><td>71%</td><td>100%</td></tr>
<tr><td>Condition change lines</td><td>0%</td><td>79%</td><td>100%</td></tr>
<tr><td>Condition labels</td><td>0%</td><td>86%</td><td>100%</td></tr>
<tr><td>Data points and path</td><td>0%</td><td>93%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>0%</td><td>79%</td><td>90%</td></tr>
</table>

Based upon the review of the IBHA/PBSPs and data graphs, it did appear that improvement had been achieved and maintained in many areas. It was determined that the Facility had maintained previous ratings in two areas (25%), had regressed in no areas (0%), and had progressed in 6 areas (75%). Seven of the eight areas (88%) met criteria for substantial compliance.

<table>
<tr><th>Inter-observer agreement exists for IBHA/PBSP data</th><th>Baseline</th><th>1/2014</th><th>7/2014</th></tr>
<tr><td>IOA for target behavior data.</td><td>0%</td><td>71%</td><td>50%</td></tr>
<tr><td>IOA for replacement behavior data.</td><td>0%</td><td>0%</td><td>30%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		IOA meets minimum criteria | 0% | 0% | 20% Records reflected that some IOA data for treatment targets were reported for five of the 10 individuals (50%). Replacement target IOA was reported for three of the 10 individuals (30%). 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. Due to limitations concerning IOA data, it was determined that the Facility was not in substantial compliance with this provision.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	During the current site visit, the Monitoring Team selected a sample of 10 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 #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. In an attempt to ensure that all IBHA/PBSPs are easily read and interpreted by staff, DSSLC required that the staff instructions section of each IBHA/PBSP be written in 5th to 6th grade English. To ensure this requirement was met, IBHA/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 10 records (Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765) revealed that that the readability requirement was enforced by the peer review process.	Substantial Compliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete	The Facility indicated that verbal instruction, competency-based training (CBT), 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.	Noncompliance

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	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.	Due to the limitations in the provided documentation such as tracking data on training, the following weaknesses were evident. • There was no indication that the Facility had implemented a comprehensive system of integrity checks to assess staff competence in reference to IBHA/PBSPs and to provide competency-based retraining as needed. • The Facility did not present documentation that certain IBHA/PBSPs had been identified as requiring CBT for all staff working with a particular individual. • 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 seven staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 65 individuals residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals. The Behavior Services department did include a sufficient number of positions to achieve a 1:30 ratio. Should a BCBA credentialed employee fill each available position, the Facility would achieve approximately a 1:29 ratio. The Facility also employed sufficient Psychology Assistants to provide one Psychology Assistant for every two full-time psychologists.	Noncompliance

SECTION L: Medical Care	
	Document Reviewed : 1. DSSLC Self Assessment, 7/3/2014 2. DSSLC Action Plan, not dated 3. DSSLC Policy Med-01 Medical Quality Assurance, Exhibit H, dated 7/1/2014 4. DSSLC Death of a Resident Policy, CMGMT 01B Exhibit N and Medical – 07, dated 4/15/2014 5. DSSLC Unvaccinated DSSLC Residents Protocol, 05/29/2014 6. DSSLC Wearing and Disposing of Gloves Protocol, undated and un-numbered 7. DSSLC Multidrug Resistant Organisms Policy, Revised 05/08/2014, un-numbered 8. DSSLC Steps to Take When A DSSLC Unit/Apartment Has A Suspected/Confirmed Case of Influenza (Outbreak) protocol, dated 10/24/2014 9. List of all medical providers, including number of hours worked, case load, and employment status 10. For each medical provider a. Curriculum vita for all licensed medical providers b. Copy of current medical license for two medical providers c. Copy of current CPR certificate for all medical providers d. List of all CME obtained during the past 12 months for all medical providers 11. Copy of morning medical meeting minutes for the first meeting of each month during the reporting period. 12. List of all current Do Not Resuscitate (DNR) orders 13. For Individuals #92, #499, #177, #365, and #28 a. Most recent annual medical assessment. b. Annual ISP. c. Documentation by the medical provider documenting the qualifying condition and rationale for the DNR. d. Copy of the current DNR order form. e. Ethics review of the DNR order f. Documentation that direct service professionals have been informed of the DNR 14. For Individuals #228, #339, #594, #298, #175, #52, #433, #5, #706, and #723: a. All medical provider Integrated Progress Notes (IPNs) documenting initial assessment and follow-up through full resolution of the acute medical condition b. All nursing IPNs documenting the initial assessment of the acute medical conditions and follow-up through resolution of the acute medical conditions c. All relevant consultation and diagnostic reports for the acute medical condition 15. For Individuals #705, #293, #509, #666, and #158: a. Most recent annual physician's summary b. All medical provider's assessments for the diagnosis of hypertension c. All relevant diagnostic and consultation reports for hypertension d. Most recent Integrated Risk Rating Form (IRRF) 16. List of all fractures that occurred during the reporting period

	17. Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures and attempts to mitigate fractures 18. For Individuals #170, #75, #642, #506, and #307: a. Most recent annual medical assessment b. Medical provider's IPNs specific for the assessment and management of fracture c. Medical provider's IPN documenting the possible etiology of the fracture d. Most recent two IRRFs e. IDT minutes, ISP, or other documentation indicating an IDT review of the fracture f. Most recent bone density g. Most recent medication list 19. Alpha list of all individuals who developed pneumonia during this reporting period 20. List of all individuals who developed at least three or more episodes of pneumonia during the past five years 21. For Individuals #499, #66, #776, #279, and #170: a. Most recent annual physician's summary b. Most recent quarterly medical review c. Most recent IRRF assessment d. All medical provider's IPNs documenting initial assessment and follow-up of pneumonia e. All diagnostics, and consultations, specific to the most recent episode of pneumonia f. Medical provider's IPN, and other evidence documenting the etiology of recurrent pneumonia, and steps taken to help reduce or mitigate recurrent pneumonia 22. Copy of all summaries, graphs, and data used for the external medical provider quality assurance audits 23. Documentation of all action plans 24. Documentation of follow-up of action plans through full implementation of the action plan 25. Documentation of assessment of the medical provider audits by the external physician reviewer 26. 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 27. List of all indicators used to assess medical competency 28. Examples of the following medical quality assurances processes: a. External Medical Quality Assurance Audit b. External Medical Management Audit c. Internal Medical Quality Assurance Audit d. Internal Medical Management Audit e. Assessment of the Assessments f. Medical Management Assessment g. Community Living Discharge Plans (CLDP) Pre-Placement Quality Assurance Review h. Death and Mortality Reviews i. Medical Record Audit j. Clinical Indicators and Outcome Data Review k. Physical and Nutritional Management Committee

	l. Medication Variance Data Review m. Review of Provider Participation in the ISP Process n. Review of Documentation and Clinical Practice o. Quality of Medical Care Site Review p. Medical Quality Assurance Report 29. Medical quality assurance meeting minutes for 4/29/2014, 5/28/2014, and 6/26/2014 30. QA/QI data meeting minutes, dated 5/24/2014, or 6/26/2014. 31. Active clinical records for Individuals #716 and #760 32. Review of Clinical and Administrative Death Committee Review Reports and required documentation associated with the deaths for Individuals #573, #211, #341, #719, #423, #136, #606, #187, #305, #53, #11, #129, #242, #336, #576, #743, #760, and #602 33. Review of the Death Review Tracking Spreadsheet for Individuals #573, #211, #341, #719, #423, #136, #606, #187, #305, #53, #11, #129, #242, #336, #576, #743, #760, and #602 34. Review of Clinical and Administrative Death Review Committee Recommendation Tracking Spreadsheet for Individuals #573, #211, #341, #719, #423, #136, #606, #187, #305, #53, #11, #129, #242, #336, #576, #743, and #760 **Interviews:** As listed below **Meetings Attended/Observation:** 1. Death Review Meeting with the following staff: • Nancy Condon, Facility Director • Stanley Cal, MD, Medical Director • Diane Tompkins, Health Services Compliance Coordinator • Delia Schilder, RN, Chief Nurse Executive (CNE) • Paula Horn, Habilitation Director • Laura Stoffels, RN, Nurse Investigator • Dora Tillis, Assistant Director of Programs • Lori Powell, Quality Assurance Director • Erin Knight, State Office Observer 2. Meeting to discuss influenza practices, with the following staff: • Nancy Condon, Facility Director • Stanley Cal, MD, Medical Director • Diane Tompkins, Health Services Compliance Coordinator • Delia Schilder, RN, Chief Nurse Executive (CNE) 3. Integrated Morning Meeting, 7/23/2014
	Facility Self-Assessment: Following its review of the self-assessment for Section L, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and

	record reviews to determine status of compliance with the respective monitoring processes. For example, there were no standards of care or clinical indicators documented to assess the provision of medical services. • The Self-Assessment did identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but just overall percentage of compliance. • The Monitoring Team could not determine if the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility determined that it was not in substantial compliance with Sections L.1, L.2 and L.4, and was in substantial compliance with Section L.3. The Monitoring Team concurs with the Facilities assessment of noncompliance with Sections L.1, L.2, and L.4, but disagrees with the assessment of substantial compliance with Section L.3. The Monitoring Team determined that because the Facility had not developed a medical quality assurance process that assesses clinical outcome data and compares the Facility's data to benchmark data derived from professional bodies, and because the medical quality assurance process primarily assesses medical providers, and not other professional disciplines that contribute to the provision of medical care.
	Summary of Monitor's Assessment: The Facility has made extraordinary efforts to move the Facility closer to compliance with Sections L.1 through L.4. The Facility developed and implemented many new policies, including a policy to ensure appropriate actions following the death of an individual, and a comprehensive quality assurance policy. The Facility is currently developing and implementing a comprehensive medical quality assurance process, has significantly enhanced its integrated morning meeting process, and ensures prompt and appropriate initial triage of acute medical conditions. Furthermore, the Facility had made significant improvements with its review process for DNR orders. The Facility, however, must continue to improve its, as the Monitoring Team noted deficient areas in the management of pneumonia, follow-up to chronic care conditions, development of medical action plans, follow up to acute medical conditions through full resolution of the condition, medical audit reviews, medical quality assurance process, and mortality review process. For these reasons, the Facility is not in substantial compliance with Sections L.1 through L.4.

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L1	Commencing within six months of the Effective Date hereof and with	To assess compliance with Section L.1 of the Settlement Agreement, the Monitoring Team observed individuals at their homes and day programs, attended the Integrated Morning	Noncompliance

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	full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Report (IMR) meeting, and discussed compliance issues with the medical director. Section L.1 is most comprehensive, and for this review period the Monitoring Team assessed the following topics: • Medical Administration • Medical management of pneumonia and recurrent pneumonia • Medical management of fractures • Medical management of acute medical conditions • Medical management of chronic care conditions: Hypertension • The Facility's review of DNR orders and process <u>Medical Administration</u> 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: • List of all medical providers, including number of hours worked, case load, and employment status • For each medical provider o Curriculum vita for all licensed medical providers o Copy of current medical license for two medical providers o Copy of current CPR certificate for all medical providers o List of all CME obtained during the past 12 months for all medical providers • Copy of morning medical meeting minutes for the first meeting of each month during the reporting period. Medical Providers: The Facility maintained one full time clinical director, six full time staff physicians, one part time contract physician, and two nurse practitioners. Current medical licenses were reviewed, and all medical providers were currently licensed by the State of Texas. Copies of a current CPR certificate were provided for ten out of the ten medical providers (100%). All medical providers had participated in continuing medical education (CME) activities during the previous 12 months. There was no indication that CME venues were developed or provided for specific topics related to intellectual and developmental disabilities. For example, medical providers should be enabled to participate in educational topics covering issues such as chronic constipation, neuromotor and musculoskeletal conditions, restrictive lung disease, polypharmacy, and dysphagia,	

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		among others that relate to conditions and issues commonly found with this population. The Facility did provide a list of other medical training provided. The Monitoring Team compliments the Facility for providing the following training venues for it's medical providers: • 2/10/2014: Issues in: Reactive and Restrictive Airway Disease, and Tracheostomy Reversal/Decannulation by Dr. Jamal Mubarak, Pulmonologist • 5/8/2014: Airway Clearance Seminar by Hill-rom for RTs and Nurses • 6/25/2014: Autism and Challenges in Physical Medical Assessments by Dr. Karen Toussaint, Assistant Professor at UNT Department of Behavior Analysis and UNT Autism Center • 7/1/2014: Preventing Treating Eye Infections in the DSSLC Population by Dr. Emery Huber 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. Daily Integrated Morning Report (IMR) meetings: The Facility conducts a daily IMR, that meets on regularly scheduled business days to review all on-call issues that occurred the previous night, review current hospitalizations, update on individuals in the infirmary, and discuss significant clinical issues. 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. The Monitoring Team attended the morning meeting on 7/23/2014, and noted significant improvement in the overall functioning of the meeting, compared to previous compliance review visits. The meeting appeared well organized; the participating clinical pharmacist had computer access to clinical data, and presented real-time information on relevant clinical issues; medical providers actively participated at the meeting, and provided meaningful clinical insight for cases discussed; nursing and other professionals were observed to be equally engaged. The Monitoring Team reviewed the following IMR minutes: 2/3/2014, 3/3/2014, 4/1/2014, 5/1/2014, 6/2/2014, and 7/1/2014. The Monitoring Team noted improvement in completion of IMR minutes by enhanced documentation of the clinical issues, including a brief overview of the medical plan, and reporting the committee's follow-up plans. Summary:	

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		The Monitoring Team's direct observation of the IMR meeting, and review of the IMR meeting minutes, indicated significant improvements had been made. The meeting was well integrated, participants provided meaningful clinical insight, and recommendations, and IMR minutes included necessary clinical information and follow up plans. The Monitoring Team compliments the Facility on this improvement of the IMR process, and believes that its IMR process will lead to enhanced clinical outcomes. <u>Management of end-of-life issues / do not resuscitate (DNR)</u> The Monitoring Team requested a list of all active DNR orders, and for the first five individuals on the list, a copy of the most recent annual medical assessment, annual ISP, documentation by the medical provider documenting the qualifying condition 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 (Individuals #92, #499, #177, #365, and #28): • In four out of five examples (80%), the code status was documented on the annual physician's summary. The Monitoring Team noted for the one example that did not include the code status, the individual was diagnosed with a terminal illness shortly after completion of the annual physician's summary, and noted that the Physician had completed an IPN documenting the clinical rationale for the DNR. • In five out of five examples (100%), there was evidence of a clinically appropriate qualifying condition for a DNR order. • In one out of five examples (20%), the medical provider documented an overview statement justifying the DNR status on the annual physician's summary. The example for Individual #365 included an over statement, under the heading of resuscitative status. • In four out of five examples (80%), the medical provider documented an IPN documenting the clinical rationale for the DNR. It would be advantageous if the clinical rationale was include on the annual physician's summary. • In four out of five examples (80%), the ISP included documentation of the DNR status. • In four out of five examples (80%), there was documentation of a review by the Facility's ethics review committee that included a review of the qualifying condition. • In five out of five examples (100%), an individualized procedure for providing DNR was developed for each individual, as outlined on the Direct Support Professionals Instructions form. Summary: The Monitoring Team noted significant improvement with the DNR process, by ensuring	

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		clinical appropriate qualifying conditions being documented for each example reviewed, providing individualized instructions for direct support staff on the DNR, ensuring that an ethics review process is in Place to help ensure the appropriateness of the DNR, and by ensuring DNR consent and order forms are completed appropriately in most examples reviewed. The Monitoring Team is complementary to the Facility for enhancing its DNR process. The Monitoring Team suggests that including a brief overview of the qualifying condition, along with the current code status, would help clinical providers' continuity of care, in the event that a medical provider changes caseload. <u>Assessment, treatment, and follow-up to acute medical conditions</u> To assess the Facility's triage of acute medical conditions, the Monitoring Team reviewed the following documents, for acute medical conditions that occurred during February 2014 through June 2014, for a total of nine examples reviewed (Individuals #228, #339, #594, #298, #175, #52, #433, #5, and #706): • All medical provider IPNs documenting initial assessment, and follow-up through full resolution of the acute medical condition • All nursing IPNs documenting the initial assessment of the acute medical conditions and follow-up through resolution of the acute medical conditions • All relevant consultation, and diagnostic reports • There were no examples provided that required urgent medical consultations For the examples reviewed: • Initial medical treatments appeared clinically appropriate in nine out of nine examples (100%) • The medical provider documented a comprehensive initial IPN that included a physical assessment and clinically relevant medical plan in eight out of nine examples (90%) • The medical provider documented follow-up IPNs, through full resolution of the acute medical condition in nine out of nine examples (100%). • The nurse documented an initial IPN for the acute medical condition that indicated a need for notification of the medical provider and included a nursing assessment in five out of nine examples (56%). • The nurse documented follow-up IPNs, through full resolution of the acute medical conditions in seven out of nine examples (78%). The following are four examples to better delineate the Monitoring Team's concern with the lack of documented medical follow-up for acute medical conditions: • Individual #5: On 2/28/2014, the nurse documented in the IPN that the Individual had 400 cc of blood tinged urine, following a straight catheterization, and there was evidence that the nurse documented notification to the medical	

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		provider. The medical provider documented a brief clinical, and limited physical, assessment that did not include palpation of the abdomen, and concluded a diagnosis of possible "early dehydration"; there was no comment about the volume of urine collected, or that it was blood tinged. Later the same day the Individual was transferred to the infirmary, for "dehydration," and there was no additional follow-up IPN by the medical provider until 3/1/2014, when the medical provider documented an IPN that did not include a physical assessment. Fifty minutes later, the nurse obtained a verbal order from an alternate medical provider to transfer the Individual to the acute care hospital for urinary retention. The Monitoring Team is concerned that the medical provider's IPN documentation did not include subjective information to include possible blood tinged urine, the large amount of urine that was catheterized, lack of a comprehensive physical examination that should have included an abdominal assessment, and no physical assessments being completed following the initial assessment. • Individual #433: The Individual was diagnosed and treated on 4/30/2014 for bronchitis, and an x-ray of the lungs was obtained that same day. The radiologist recommended, and the medical provider documented, , that a repeat chest x-ray was necessary because of malposition of the Individual that limited the x-ray findings. There was no documentation provided to indicate a follow-up x-ray was completed, and no documentation by the medical provider indicating a rationale for not ordering a follow-up chest x-ray. Review of the x-ray report of the lung indicated concern for possible air-trapping, secondary to obstruction or airway disease. There was no follow-up documentation by the medical provider for this acute medical condition. • Individual #706: A medical provider IPN was documented on 3/24/2014 that documented a diagnosis of "early cellulitis rt axilla", and indication that the Individual was prescribed antibiotic therapy and would be seen for follow-up in 72 hours. The only other medical provider IPN was dated 4/30/2014, by the same medical provider, that stated "informed by nurse that pt has large area of infected hydradenitis rt axilla as well as an area in groin on rt". There was no indication that a physical assessment was completed, and the medical provider documented an assessment was documented as "cellulitis rt axilla/groin", and a medical plan to administer antibiotic therapy was documented. The Monitoring Team is concerned that there was no indication of close follow-up by the medical provider for the diagnosis of cellulitis, and because the second of two IPNs by the medical provider suggested only a verbal discussion with the nurse, with no physical assessment documented. • Individual #298: On 4/1/2014 a nursing staff documented an IPN indicating swelling of left cheek, and a medical provider's IPN documented a physical	

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		assessment on 4/1/2014 that documented a physical examination of a left swollen cheek, and a documented plan to "report increased swelling, f/u as needed". Nursing IPNs documented continued swelling of the cheek on 4/2/2014 and 4/3/2014. The nursing IPN dated 4/3/2014 also indicated the need for "continue to monitor until resolved". There were no addition nursing IPNs that documented this issue, and there was no indication that the medical provider documented additional follow-up IPNs through resolution. The Monitoring Team is concerned that nursing staff did not continue to document follow-up IPNs through resolution, and that the medical provider did not document follow-up IPNs through resolution. Furthermore, there was no indication that a medical or dental evaluation was completed to assess for the etiology of the swelling; as a dental issue may have contributed to the swelling. Summary: The Monitoring Team is concerned that the Facility's medical providers did not document follow-up IPNs, through full resolution of the acute medical conditions. The medical provider should periodically assess individuals to ensure that therapeutic interventions are being appropriately provided, and that the Individual is responding to prescribed treatments. In some examples, as delineated above, medical providers documented limited, or no, physical examinations. <u>Assessment, treatment, and follow-up of chronic medical conditions</u> To assess the Facility's management of chronic medical conditions, the Monitoring Team reviewed the following documents, for the first five individuals, on a list of all individuals with a diagnosis of hypertension. (Individuals #705, #293, #509, #666, and #158): • Most recent annual physician's summary • All medical provider's assessments for the diagnosis of hypertension • All relevant diagnostic and consultation reports for hypertension • Most recent IRRF Results following a review of the clinical documents for Individuals #705, #293, #509, #666, and #158: • The most recent annual physician's summary indicated a diagnosis of hypertension in five out of five examples (100%). • The most recent annual physician's summary documented a comprehensive medical plan that listed medical, and non-medical management, necessary diagnostics, medical follow-up, and specific monitoring and reporting parameters for hypertension. • Clinically appropriate medical treatment was provided for the diagnosis of hypertension in four out of five examples (80%). • The IRRF documented clinically relevant information for the diagnosis of	

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		hypertension, and included specific monitoring and reporting parameters, in one out of five examples (20%) • Necessary diagnostic studies were provided for review in zero out of five examples (0%). The Monitoring Team was not provided evidence that urine protein analysis was completed, at least annually. • There was evidence that the medical provider periodically performed clinical assessments of the individual, outside of the annual physician's review, by reviewing average blood pressure results, necessary monitoring labs, and documenting a physical assessment in one out of five examples (20%). There following are specific comments and concerns regarding the Monitoring Team's review of the provided documents: Individual #705: • The most recent annual physician's review documented a blood pressure of 129/99, and a corresponding plan indicating that Blood pressure was under control. A diastolic blood pressure of 99 is not considered under control, and warrants assertive follow-up and treatment, if clinically necessary. In this example, the medical provider did not address the documented diastolic pressure reading. • The Individual had an echocardiogram and consult with a cardiologist in November 2014, that reported a diagnosis of diastolic dysfunction, and need for good blood pressure control. The diagnosis of diastolic dysfunction was not listed as a diagnosis on the most recent annual medical summary. • An EKG, dated 4/7/2013, indicated "bilateral atrial enlargement", and there was no documentation of this diagnosis provided. • The most recent IRRF, dated 7/28/2014, did not comment on monitoring and reporting parameters for bilateral atrial enlargement (cardiomegaly), or diastolic dysfunction. Given the diagnoses of hypertension, cardiomegaly, and diastolic dysfunction, the Monitoring Team was very concerned that the IRRF documented "does not have circulatory disease", and "does have occasional swelling in her bilateral lower extremities but it resolves without medical intervention". The swelling of the Individual's legs may indicate worsening cardiac dysfunction, and indicate development of heart failure, and there was no indication of a differential diagnosis being entertained by the medical provider. Furthermore, the risk level for cardiac disease was not listed on the most recent IRRF assessment. • The Monitoring Team has concern that the Individual had not followed up with a cardiologist since 2011, for the diagnoses of diastolic dysfunction, hypertension, and cardiomegaly. Given that the Individual's diastolic blood pressure was 99, a	

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		recent EKG indicated bilateral cardiac hypertrophy, and there were clinical signs of bilateral swelling of the legs, consultation with a cardiologist should have been considered. • There was no indication that the medical provider periodically assessed the diagnoses of hypertension, diastolic dysfunction, and cardiomegaly throughout the year. Periodical physical assessments, and documentation of average blood pressures, should be periodically completed. • The Monitoring Team is very concerned that the only monitoring parameters for blood pressure was for systolic blood pressure readings, and not diastolic blood pressure readings. For this Individual, careful monitoring of diastolic blood pressure can be critical. Individual #293: • An IPN, dated 7/16/2014, documented a specific "chronic disease exam", which included a physical examination, assessment, and plan. The IPN indicated "somewhat labile pressure – many in normotensive range & others in 140 150/s/90s". The assessment was "HTN → fairly stable", and to "continue current management". The Monitoring Team is complimentary that hypertension was comprehensively assessed, as part of a review of chronic care management. The IPN, however, did not comment on an EKG report of 6/2/2014, indicating sinus bradycardia, and possible left ventricular hypertrophy. • The IRRF did not list necessary supports for the monitoring, reporting, and follow-up on hypertension. • The most recent annual physician's summary indicated a diagnosis of hypertension, but did not classify the stage of hypertension, and documented a comprehensive plan for hypertension that included review of average blood pressure readings, strategies for medication usage, and monitoring, as well as strategies for dietary management, and physical activity. The Monitoring Team is complimentary of the development of a medical plan that included non-medical management strategies (including dietary and physical activity plans), but recommends that the plan includes specific monitoring and reporting parameters for hypertension. Individual #509: • No specific comment for hypertension was documented on the most recent IRRF. • The most recent active problem list, dated 1/11/2010, indicated a diagnosis of hypertension; however, the most recent annual physician's summary did not include a diagnosis for hypertension, or a plan for hypertension; and there was	

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		no additional documentation indicating an assessment or follow-up for hypertension by the medical provider. • The most recent IRRF documented that an EKG was performed, that indicated mild left ventricular hypertrophy (LVH). LVH may be secondary to chronic hypertension, and there was no documented evidence provided indicating that the condition was assessed by the medical provider. Individual #666: • There was evidence of abnormal echocardiogram, and appropriate follow-up with a cardiologist. • The IRRF did not include a comment for the diagnosis of hypertension. • The Monitoring Team compliments the Facility for including a current diagnosis of hypertension on the most recent annual physician's assessment, and including a plan that documented medical managements, dietary issues, and monitoring parameters for hypertension. • There was no evidence provided that the medical provider completed a physical assessment, or review of average blood pressures, outside of the annual physical assessment. The Monitoring Team noted a chronic problem progress record note, documented on 5/30/2014; however, this note only indicated a "meeting with rn case manager", and did not specify a physical assessment or review of average blood pressure reading. Individual #158: • The Monitoring Team noted the diagnosis of hypertension on the most recent annual physician's summary, and a medical plan that included monitoring parameters for hypertension; however, the plan did not address non-medical treatments for hypertension. • There was no evidence that hypertension was periodically assessed, out side of the annual physician's summary. Summary: The Monitoring Team noted some improvement with medical provider's documentation and management of chronic clinical conditions; however, the Facility must continue to enhance this process by ensuring that the medical provider provides periodic clinical assessments that include physical assessments, and review of diagnostics and clinical data, as necessary. Also, the Facility must develop a comprehensive clinical plan for each chronic care condition. The plan should include medical treatments, clinical follow-up, and monitoring and reporting parameters. In addition, the IRRF must reflect monitoring and reporting parameters for all chronic care issues.	

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		<u>Clinical management of fractures</u> The Facility reported 13 individuals as having a fracture during the reporting period. To assess the Facility's clinical ability to manage fractures, the Monitoring Team requested the following information: • Alpha list of all individuals who sustained a fracture during the reporting period • Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures • For the last five individuals on the list of fractures (Individuals #170, #75, #642, #506, and #307) o Most recent annual medical assessment o Medical provider's IPNs specific for the assessment and management of fracture o Medical provider's IPN documenting the possible etiology of the fracture o Most recent two IRRFs o IDT minutes, ISP, or other documentation indicating an IDT review of the fracture o Most recent bone density o Most recent medication list The following is a summary of the Monitoring Team's findings, following its review of Individuals #170, #75, #642, #506, and #307: • In five out of five examples (100%) the medical provider conducted a prompt initial triage for reported fractures. • In three out of five examples (60%) the medical provider regularly followed the Individual through full resolution of the fracture. • In four out of five examples (80%) the medical provider obtained necessary diagnostics and prompt consultation for the assessment and treatment of fracture. There was no documented consideration for an orthopedic consultation for Individual #75. • In zero out of five cases (0%), the medical provider documented a comprehensive assessment of all risk factors for fall and fracture. The medical provider should review all potential clinical manifestations for fractures, including physical anomalies, abnormal gait, medication usage, and behavioral manifestation. • In one out of five cases (20%), the IRFF documented a comprehensive assessment of all risk factors for fall and fracture. The following are some comments, and concerns specific for the management of fractures, for the examples reviewed by the Monitoring Team:	

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		Individual #170: • The medical provider did not document follow-up IPNs, with the exception of one IPN documented on the day following the fracture. Given the severity of the fracture, the medical provider should have periodically assessed to ensure that all necessary supports and services were in place, assessed efficacy of treatment, and assessed pain. • The medical provider did not document an assessment as to the cause, or potential cause, of the fracture. • The Individual was noted to have sustained multiple fractures in the past, that included a previous fracture of the leg, knee, and upper arm, and there was no medical plan documenting the Individual's risk for fracture, or necessary supports and services to help mitigate fractures. Furthermore, the only medical plan documented for osteoporosis was "continue with calcium supplements and dexa q two years"; there was no specific plan documented for vitamin D requirements, or necessary supports and services to help mitigate worsening osteoporosis and related fractures. The Individual was also prescribed nasal calcitonin, and there was no documentation on the medical plan indicating its clinical efficacy or usage by the Individual. • The Individual was on several medications, including valproic acid, which is known to cause osteoporosis. There was no documentation as to the risk and benefits for such medications, or possible alternative treatments. Individual #75: • The individual sustained an injury that resulted in a fracture on 6/20/2014, and was triaged to the emergency department. Follow-up CT scan dated 6/26/2014 demonstrated a comminuted fracture of the left calcaneus, with some signs of healing, and indication that the fracture traversed the region of attachment of the Achilles tendon. Because of the possibility of involving the Achilles tendon the Facility should have documented follow-up with an orthopedic specialists, or clinical rationale for not considering follow-up with an orthopedic surgeon. • The provider documented a comprehensive initial assessment of the fracture, and appropriately followed the Individual after the initial assessment. • The Monitoring Team noted concerns related to the most recent IRRF. For example, the IRRF was dated 4/23/2014, and did not indicate that it had been amended, or updated; however, under fractures the IRRF documented "one fracture noted in past year on 6/23/2014." Also, under the section for current status, it was documented "stable status of risk, no episodes of any fractures noted in past year." For the section of proposed recommendations/rationale, it was documented "continue current supports and services; however, a recent	

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		injury assessment dated 7/10/2014 indicated additional supports to help mitigate fractures." Given the severity of the fracture, the reported cause of the fracture, discrepancy of dates on the IRRF, and enhanced services documented on the injury assessment, the Facility should have updated to IRRF to reflect necessary supports and services. • There was no evidence by the medical provider that diagnosed the etiology, or possible etiology, of the fracture; other than completing the injury report on 6/20/2014. The medical provider should document a clinical review of the fracture, and indicate possible causes for the fracture. • The medical plan for osteoporosis was very limited, and did not document specific supports and services to help mitigate fractures. Individual #642: • The Monitoring Team compliments the Facility for ensuring that previous diagnoses of fractures were included on the most recent annual physician's summary problem list; however, there was no medical plan developed for recurrent fractures, and the medical plan for osteoporosis did not list necessary supports and services for osteoporosis. • The Monitoring Team compliments the Facility for ensuring a comprehensive initial assessment of the fracture, assertive initial treatment, and frequent follow-up assessment by the medical provider. • The most recent IRRF did not document a comprehensive review of fracture risks, despite multiple risks factures that include medications and physical anomalies. Individual #506: • The Monitoring Team compliments the Facility for its prompt and comprehensive initial assessment, treatment, and follow-up for a fracture. • There was no indication that the medical provider assessed all known, and possible, etiologies for fracture. Individual #307: • Under the section listed as supports, the most recent annual physician's summery documented an exceptional assessment of fall risk and fracture prevention strategies. The medical action plan for osteoporosis documented the need for "safety precautions to reduce fractures", as well as documenting the current medical treatment, follow-up medical services, and efficacy of medical treatment. • There was no documented evidence indicating that the medical provider followed up on the diagnosis of multiple rib fractures, following the initial	

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		assessment. • The most recent IRRF reflected an update and comment on the rib fractures. Summary: The Monitoring Team noted continued improvement with documentation of acute medical conditions, as all fractures were promptly assessed by the medical provider. The Facility should enhance the medical provider's follow-up of fracture, to assess for pain management and treatment efficacy, and to ensure that necessary supports and services are effective. The medical provider should assess all known, and potential, risks of fracture, and for individuals at risk for fractures, should ensure a comprehensive medical plan for fractures. <u>Clinical Management of pneumonia</u> To assess the Facility's management of pneumonia, the Monitoring Team requested the following information: • Alpha list of all individuals who developed pneumonia during this reporting period • List of all individuals who developed at least three or more episodes of pneumonia during the past five years • For the five individuals with the highest incidence of recurrent pneumonia, and with at least one episode of pneumonia that occurred during this reporting period: o Most recent annual physician's summary o Most recent quarterly medical review o Most recent IRRF assessment o All medical provider's IPNs documenting initial assessment and follow-up of pneumonia o All diagnostics, and consultations, specific to the most recent episode of pneumonia o Medical provider's IPN, and other evidence documenting the etiology of recurrent pneumonia, and steps taken to help reduce or mitigate recurrent pneumonia The Facility provided a list of 55 individuals who were diagnosed with pneumonia from 2/1/2014 through 7/21/2014 (12% of the 458 individuals at the Facility). The Facility provided a list of 62 individuals, who were known to have three or more episodes of pneumonia during the past five years. Review of this list indicated that 26 of the 62 individuals (42%) developed an episode of pneumonia during this reporting period; 17 were prescribed enteric tube feeding, nine a specialized diet, and one a	

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		regular diet. Many of the individuals diagnosed with recurrent pneumonia had a significant incidence of pneumonia, over the past five years; for example: • Individual #201 experienced 20 incidences of pneumonia, two of which occurred during this reporting period. • Individual #499 experienced 20 incidences of pneumonia, five of which occurred during this reporting period. • Individual #66 experienced 17 incidences of pneumonia, three of which occurred during this reporting period. • Individual #279 experienced 15 incidences of pneumonia, four of which occurred during this reporting period. • Individual #776 experienced 14 incidences of pneumonia, two of which occurred during this reporting period. • Individual #466 experienced 12 incidences of pneumonia, two of which occurred during this reporting period. • Individual #170 experienced 12 incidences of pneumonia, two of which occurred during this reporting period. • Individual #551 experienced 11 incidences of pneumonia, two of which occurred during this reporting period. The following is a review of the Monitoring Team's findings from review of the last five individuals on the list of individuals with recurrent pneumonia. • The diagnosis of recurrent pneumonia, or aspiration pneumonia was listed as a diagnosis on four out of five examples (80%). • A clinically rational medical action plan to help mitigate the recurrent pneumonia was documented on the annual medical assessment in one out of five examples (20%). • There was documented evidence that the medical provider regularly assessed the individual for recurrent pneumonia, and reviewed and assessed efficacy of prescribed supports and services for recurrent pneumonia, in zero out of five examples (0%). There were some examples of quarterly progress record notes documenting recent incidences of pneumonia; however, in no examples was there a clinically relevant assessment for recurrent pneumonia, or documentation that current prescribed services and supports were effective in helping to mitigate recurrent pneumonia. • In one out of five examples (20%), the IRRF clearly delineated all necessary supports and services to help mitigate the risks associated with recurrent pneumonia. The most recent IRRF for Individual #66 is a good example of a comprehensive assessment for aspiration.	

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		The following are some comments and concerns for four of the five examples reviewed: Individual #499: • The Individual had a reported 20 incidences of pneumonia since 2010, two of which occurred during this reporting period. The Individual is known to be "tubefed"; however, the annual physician's summary did not clearly document a review of recurrent pneumonia, and the medical plan for pulmonary conditions indicated that the "patient has had several episodes of aspiration pneumonia and should be given directive to have head of bed elevated, be given proton pump inhibitor, to be monitored for H. pylori, and monitored for episodes of aspiration should he have a seizure." Because of the significant risk factors for aspiration pneumonia, the medical provider should document specific issues, or refer to a specific procedure for positioning, enteric tube feeding, usage of enteric tube for medication, and fluids, and physical transferring supports. Furthermore, for this specific case, there should be specific monitoring and reporting parameters developed for direct care and nursing staff to monitor following activity. • The Individual has an enteric tube placed, but no diagnosis of dysphagia, or other diagnosis that would require PEG placement. • The most recent IRRF, dated 3/10/2014, indicated the Individual having a G-J tube; however, it did not list the indication for this enteric tube. Furthermore, the IRRF indicated a diagnosis of gastritis, and 31 episodes of emesis during the year; The Monitoring Team has significant concern that there was no diagnosis or medical plan for the recurrent emesis or gastritis listed on the most recent annual physician's assessment. • Under the topic of aspiration, the IRRF did not document a clinically meaningful current status, and did not complete the recommendations, discussions, team deliberation, and risk rating components of the IRRF. In addition, despite the Individual having experienced many aspiration pneumonias, known aspiration risk factors, GERD, seizure disorder, recurrent emesis, and an enteric tube placement, the IRRF did not indicate that the Individual was at risk for aspiration, and documented "no history of choking in the past 3 years". The Monitoring Team is concerned that these underlying medical conditions, did not lead the Facility to consider the Individual at risk for choking. • There was no evidence documented by the medical provider indicating periodic evaluation of the individual for recurrent pneumonia diagnosis, and to assess efficacy of supports and services to help mitigate recurrent pneumonia. The medical provider should regularly assess the efficacy of all prescribed treatments, in collaboration with other health care providers, such as speech pathology and physical therapy.	

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		Individual #66: • The Individual experienced 17 episodes of pneumonia since 2010, with three episodes occurring during this reporting period. Although there was a diagnosis listed for recurrent pneumonia, there was no plan that documented specific monitoring and reporting parameters, or necessary supports and services. • The Monitoring Team compliments the Facility for the comprehensiveness of the IRRF in documenting its review, efficacy of supports and services, and plan to help reduce incidences of recurrent pneumonia. • There was no evidence documented by the medical provider indicating periodic evaluation of the individual for recurrent pneumonia diagnosis, and to assess efficacy of supports and services to help mitigate recurrent pneumonia. The medical provider should regularly assess the efficacy of all prescribed treatments, in collaboration with other health care providers, such as speech pathology and physical therapy. Individual #776: • The Monitoring Team compliments the Facility for ensuring that the annual physician's summary included a diagnosis for recurrent pneumonia, and included a comprehensive medical review and plan for the Individual's gastrointestinal issues, and for documenting a plan for aspiration pneumonia that included a review of possible etiology for recurrent aspiration pneumonia. The Monitoring Team recommends that the medical plan also include specific monitoring and reporting parameters for nursing and direct care staff to monitor for early manifestations of pneumonia. • There was no evidence documented by the medical provider indicating periodic evaluation of the individual for recurrent pneumonia diagnosis, and to assess efficacy of supports and services to help mitigate recurrent pneumonia. The medical provider should regularly assess the efficacy of all prescribed treatments, in collaboration with other health care providers, such as speech pathology and physical therapy. • The Monitoring Team has significant concerns over the Facility reporting on the most recent IRRF, dated 3/19/2014, that all supports and services are effective for aspiration risk, while referring to a nursing quarterly assessment, dated 9/4/2010, that documented 23 episodes of emesis that "resolved without any aspiration". The Monitoring Team does not understand the rationale for referencing date from an assessment of emesis that was completed in 2010, and no comparison data for the current IRRF. Upon review of the GI component of the IRRF, the Monitoring Team noted that a variety of procedures, treatments, and diagnosis were listed; however, as with the aspiration component of the IRRF, there was no documentation for recommendations, discussion, final	

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		recommendations, and risk rating. Individual #279: • The Monitoring Team noted a chronic problem progress record note, dated 3/7/2014. The note only stated "last admission to DRMC 12/9/2014 to 12/21/2013", and "pneumonia 12/9/2013, to 12/21/2013". There was no comment documenting effectiveness of current supports and services, etiology of the pneumonia, or any change in plan The medical provider should regularly assess the efficacy of all prescribed treatments, in collaboration with other health care providers, such as speech pathology and physical therapy. • The most recent annual physician's summary documented recurrent pneumonia as a diagnosis; however, the medical action plan was limited, and did not provide specifics for the monitoring and reporting parameters for pneumonia, and efficacy of current supports and services. • There was no specific diagnosis listed that would justify the placement of an enteric tube. • The most recent IRRF, dated 6/4/2014, indicated high risk for both aspiration and respiratory conditions, and documented that there was "regression of supports and services". The IRRF included new action plans, and to "continue current supports: medications, PNMP, positioning schedule"; however, there was no comment on the efficacy of staff's implementation of the current supports, including transfers, positioning, and usage of the enteric tube. Given the severity of aspiration pneumonia, the Facility should periodically assess staff's administration of prescribed supports and services, including positioning, transfers, and all usages of the enteric tube. In addition to reviewing specific clinical examples of pneumonia, the Monitoring Team reviewed the Facility's policies and procedures for management of influenza and influenza like illness. The Monitoring Team met with members of the infection control department, and provided technical assistance to the Facility on enhanced diagnostic strategies for diagnosing pneumonia in Individuals with developmental disabilities. The Monitoring Team offers the following comments, and suggestions for policies, and procedures related to influenza, and influenza like illness: DSSLC Protocol for Unvaccinated DSSLC Residents; 05/29/2014: • The protocol does not comment on limitations of vaccination effectiveness. Vaccination does not fully protect individuals from contracting influenza; therefore Individuals who are vaccinated continue to be at some risk of developing influenza. • The Protocol did not discuss the important of chemoprophylaxis during pre- and	

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		post-exposure scenarios. DSSLC Guidelines for Wearing and Disposing of Gloves, undated and un-numbered: • The Facility has a guideline for wearing and disposing of gloves, but no specific guidelines for other personal protective equipment, such as gowns and face shields. • Other supplies, such as cleaning and disinfecting supplies, and products for sanitizing hands, should be well delineated in an influenza and other infection control policy and procedure. DSSLC Policy for Multidrug Resistant Organisms, Revised 05/08/2014, un-numbered. • The policy comments on Droplet precautions for infections, but not for "colonization." Individuals with respiratory MDRO colonization may be at risk of transmitting the organisms. • The Policy did not indicated the importance of ensuring individuals who are at enhanced risk of being infected, or an increased risk of developing severe complications, are adequately protected. One may consider that individual's who have immune deficiencies, older individuals, and individuals with cardiac disease and diabetes should not be cohorted with or exposed to individuals with known infections or colonization. • The policy indicates that "wounds" should be "cultured"; however, the type of culture was not indicated. Commonly wound "swabs" are obtained, which in turn have little clinical relevance because surface tissue is contaminated; therefore wound cultures may need to be considered, if a more accurate diagnosis is required. • The policy indicated that follow-up cultures will be obtained at 24 or 48 hours after discontinuing antibiotics. Obtaining cultures at this short time period may result in false negative cultures, because the antibiotic may still be effective. Obtaining cultures at 7 to 10 days following discontinuation of an antibiotic maybe more efficacious. • The Policy should be more specific with regard to practice standards associated with isolation and cohorting. o Specific instructions for cohorting and isolation of individuals o Specific environmental control measures for the immediate environment of the cohorted/isolated individuals o Ensuring individuals who have additional risks are not cohorted o Specific standard for clearing an individual from isolation/cohorted living arrangement o Medical follow-up of the cohorted/isolated individuals	

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		DSSLC Steps to Take When A DSSLC Unit/Apartment Has A Suspected/Confirmed Case of Influenza (Outbreak) protocol, dated 10/24/2014: • There was no comment on a specific protocol for the use of rapid flu testing. • There was no comment on the use of antivirals as chemoprophylaxis (pre and post exposure). Professional guidelines suggest that pre, and post exposure antivirals be considered for at risk individuals. Individuals residing in congruent living arrangements should be considered at risk; this would also be true for those with underlying medical conditions. • The document indicates that antiviral treatment should begin after "confirming" diagnosis of influenza. Professional guidelines suggest that antivirals be administered once a "clinical" diagnosis of influenza is diagnosed, if clinically appropriate. • The Document indicates "home rest" for five days when the Individual has a "confirmed case of influenza", and did not specify the definition of confirmed. The diagnosis of influenza and influenza like illness is a clinical diagnosis, and even in the event of a negative rapid flu test, the individual should be considered for isolation or cohorting. Furthermore, the period of isolation or cohorting should be a clinical determination, and not an arbitrary period of time. • The document should comment on expectation for medical follow-up, once diagnosed with influenza or influenza like illness. A medical provider should physically assess the Individual periodically, and evaluate for dehydration, and for signs of complications, such as pneumonia. • The document did not comment on special precautions needed when it is necessary to transport an individual during a period of isolation or cohorting. In such cases, reverse isolation techniques should be considered. • The document did not comment on the need for droplet precautions, and there was no reference to a specific protocol on droplet precautions. The Facility should remind staff, and all visitors of the need to adhere to strict droplet precautions when working with, or visiting individuals at living areas with confirmed or suspected influenza, and influenza like illness. • There was no specific comment on environmental issues, such as the need for enhanced environmental control practices, including more frequent sanitizing of surfaces and equipment. The document should refer to a specific protocol for enhanced cleaning and sanitizing of environment and equipment. • The document did not comment on the need to ensure ongoing training for individuals and staff on influenza. The Facility should consider developing a training program that advises staff and individuals about the current influenza season, importance of influenza vaccine, antivirals, and steps to help prevent the spread of influenza.	

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		Summary: The Facility has made some progress by better ensuring that the medical providers include the diagnosis pneumonia on the annual physician's summary. The Monitoring Team has serious concerns with the Facility's overall management of pneumonia, and as per the previous report, the Facility must ensure a more robust assessment of physical supports and usage of enteric tubes, and that the IRRF clearly delineates all necessary supports and services to help mitigate pneumonia. The Facility should ensure that all policies and procedures related to influenza, and influenza like illness, adhere to CDC recommendations. Conclusion: The Monitoring Team compliments the Facility for enhancing many processes related to Section L.11. For example the Facility has significantly improved its integrated morning report process, ensured more assertive oversight of the Facility's DNR process, and ensured that acute medical care issues are promptly triaged. In addition, documentation of IPNs by medical providers continues to be completed when assessing medical issues. Based on this compliance review, substantial compliance will require further enhancement of follow-up on acute medical conditions through full resolution; further develop and enhance policies and procedures for the management an prevention of influenza, and influenza like, illness; ensure more frequent physical assessments, and clinical review of chronic medical conditions; and more assertively manage respiratory conditions, including pneumonia. The Facility must ensure that medical providers, and in collaboration with other clinical professionals, document periodic assessment of efficacy for all prescribed supports and services.	
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: • Copy of all summaries, graphs and data for used for the external medical provider quality assurance audits • Documentation of all action plans • Documentation of follow-up of action plans through full implementation of the action plan • Documentation of assessment of the medical provider audits by the external physician reviewer • 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 • List of all indicators used to assess medical competency	Noncompliance

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		The Facility provided completed audit forms for the internal medical provider quality assurance audits for round nine; each form had the name of the medical provider redacted. Because of the significant volume of audit forms, the Monitoring Team was unable to review all of the forms, or able to deduct meaningful data. The Facility's medical director provided a statement indicating that the results of the medical audits were reviewed with each medical provider. The Facility indicated because of confidentiality issues, the Facility would be provided by a red folder during the Monitoring Team's compliance visit to the Facility, and the results of the medical audits, including graphs, and summaries were not provided as part of the document request. For this reason, the Monitoring Team was unable to assess the Facility's external medical provider quality assurance audit process for round nine, and therefore it will be reviewed at subsequent compliance visits. During a meeting with the Medical Director and Facility Director, the Monitoring Team was informed that the State Office "is completely revising the medical audit process" to more effectively assess clinical practice of the medical providers. Conclusion: The Monitoring Team recognized that the Facility had completed round nine of the medical quality assurance audit process during this reporting period. The Monitoring Team is encouraged by the Facility's report of the State Office intent to revise the entire medical audit process, to focus more on indicators that will assess clinical outcome. Because the medical audit process is being revised, and a new process is being developed, the Facility will remain not in compliance, and compliance because summary data and outcome analysis were not provided for review, and because the Facility is developing a new process to determine medical provider proficiencies.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The Monitoring Team reviewed the Facility's new policy for medical QA, DSSLC Medical Quality Assurance Policy, Med-01 Exhibit H, dated 7/1/2014. The policy outlined an extensive medical quality assurance process that listed 16 different activities that are incorporated into the medical QA process. The processes listed included: • External Medical Quality Assurance Audit • External Medical Management Audit • Internal Medical Quality Assurance Audit • Internal Medical Management Audit • Assessment of the Assessments • Medical Management Assessment • Community Living Discharge Plans (CLDP) Pre-Placement Quality Assurance Review	Noncompliance

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		• Death and Mortality Reviews • Medical Record Audit • Clinical Indicators and Outcome Data Review • Physical and Nutritional Management Committee • Medication Variance Data Review • Review of Provider Participation in the ISP Process • Review of Documentation and Clinical Practice • Quality of Medical Care Site Review • Medical Quality Assurance Report The Monitoring Team noted that External Medical Management Audits were to be reviewed by a physician certified as an American Board of Quality Assurance and Utilization Review physician, who is not employed by the Facility. The Monitoring Team recognizes the benefit of having a qualified medical QA physician involved in the process, but recommends that the review process ensures that the physician reviewing medical practice, in the context of a development disability Facility, has expertise in the medical management of individuals with complex physical and psychiatric conditions. The Policy documented that each of the 16 activities are tracked and trended, and that action plans are to be developed for deficits; however, there is no process to assess efficacy of action plans. The Facility must include a process that assesses efficacy of action plans developed for remediation of medical providers, and system issues. <u>Medical Management Assessment Process:</u> The Facility further developed a process called the medical management 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 provider's clinical performance. The Facility currently tracks the clinical performance for the treatment of 11 of the most frequently diagnosed medical conditions, including heart disease, pneumonia, metabolic syndrome, and renal disease. For this process, the external reviewing physician reviews the annual medical assessment of a randomly chosen individual for each medical provider each month, for a total of eight reviews per month. Based on the review of the annual medical assessment, the reviewing physician will develop action plans to rectify deficient areas; and the Facility's QA/QI department reviews, tracks, and trends completion of the action plans. The Monitoring Team was provided graphical data of the results from recent	

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		assessments; however, there was no summary statement or analysis of the data provided for review. For this reason, the Monitoring Team was unable to determine the overall efficacy of this process. Based on review of the provided graphs, and document describing the process, the Monitoring Team is impressed by the process made in working towards developing a medical QA process that focuses on clinical indicators. The Facility developed eight quality indicators that are incorporated into a medical quality assurance process; diabetes, osteoporosis, hypertension, metabolic syndrome, seizure disorder, constipation, Downs Syndrome, and emergency room admissions. The Monitoring Team compliments the Facility for its initial steps in developing a medical quality assurance process that assesses clinical care, through the evaluation of clinical indicators. Following review of the eight clinical indicators, the Monitoring Team noted some areas that require further development. Following are comments, concerns, and considerations for some of the issues identified. The Facility should note that this is not a comprehensive list of issues, but a limited example: • Quality indicator for osteoporosis: o Did not assess if the underlying etiology of low bone density was determined, as this is critically important before starting initial therapy. o Did not assess specific preventive or treatment dosages of calcium and vitamin D supplementation o Assumed that bisphosphonates should always be included a treatment plan for osteoporosis o Did not assess if drugs that manifest low bone density, such as certain anticonvulsants, were assessed and medication management was considered. • Quality indicator for hypertension: o Stated, "is there an obesity co-morbidity". This is a question, but does not assess if the treatment team has initiated an effective strategy to help the individual maintain an appropriate diet. o Did not assess if blood pressure readings were appropriate ordered, and reviewed by the medical provider. The medical provider should regularly assess, and document a review of, blood pressure readings. o Determines if a lipid panel was obtained annually, but does not comment of results. It is important to determine if the medical plan is effective in keeping components of a lipid panel in appropriate ranges. • Quality indicator for metabolic syndrome: o Did not assess if the treatment team reviewed the usage of medications that contribute to metabolic syndrome, or if a person with pharmacological risk factors was assessed for metabolic syndrome. o Did not determine if triglycerides, HDL, and fasting glucose levels were	

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		in appropriate range. To assess efficacy of treatment, the Facility will need to determine if treatment plans are efficacious by monitoring outcome measurements of lipids, and fasting glucose o Did not assess if abdominal girth was determined, and if so, is the treatment plan to help with weight reduction effective. o The indicator did not differentiate between monitoring for metabolic syndrome, and monitoring following the diagnosis of metabolic syndrome. This differentiation is important because the frequency of obtaining diagnostic tests is different for both situations. • Quality indicators for seizure disorder o Did not assess if the specific seizure type was diagnosed. This is extremely important because anticonvulsant therapy is different for different types of seizure conditions. In fact, the treatment for one type of seizure disorder may exacerbate a different type of seizure control. o Did not determine if seizures were controlled, per a specific treatment plan for the individuals. This is very important because each individual should have a determined seizure frequency documented on the treatment plan. o Did not assess if medication management was appropriate for the specific type of seizure disorder. • Quality indicators for constipation: o The indicator assesses to ensure that fiber supplement was order. For certain individuals with complex physical disabilities, certain types of bowel conditions, immobility, and inability to take adequate fluid intake, fiber supplements can results in severe constipation, obstruction, and perforation. The assessment should determine if fiber is indicated, and if so, was it prescribed, and if not, was the clinical rationale for not prescribing fiber supplementation appropriate. o Did not assess if specific fluid management was ordered, and assessed. o Did not document etiology of constipation. o Did not assess if medication usage of pro-constipating drugs was optimized. o Did not quantitate the number of stat anticonstipation medications, such as enemas, and laxatives, that were used. • Quality indicators for Down Syndrome: o Did not assess monitoring, and monitoring outcome, for functional decline. Many individuals with Down Syndrome develop degenerative spine disease, and manifestations of degenerative spine disease. o Did not assess periodic evaluation for dementia. o Did not assess regular cardiac evaluation. Individuals with Down	

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		Syndrome can develop arrhythmias and cardiac valve disease, and documentation of regular assessments for such conditions is necessary. o Did not assess the medical provider's periodic assessment of hematologic conditions, and when hematological conditions occur, were they appropriated diagnosed and managed by the medical provider. <u>Review of Medical Quality Assurance Meetings:</u> The Facility conducts monthly medical quality assurance meetings that include all members of the medical department, the Facility director, and the health services compliance coordinator. The Monitoring Team reviewed medical quality assurance meeting minutes for 4/29/2014, 5/28/2014, and 6/26/2014. Review of the minutes indicated the agenda for each meeting was variable, and there did not appear to be a standardized review of clinical outcome data, and analysis of outcome data to assess medical care. For example, the April 29, 2014 minutes reflected a discussion about caseloads, preventive care flow sheet, and medication variances, among other topics; while the 6/26/2014 meeting minutes reflected a review of timeliness of assessments, pulmonary articles, and "The List", among other topics. The Monitoring Team was concerned that the Facility's QA/QI data meeting minutes, that documented data on pneumonia, hospitalizations, infections, and deaths that occurred at the Facility, was not reviewed at either the 5/24/2014, or 6/26/2014 medical quality assurance meetings. While all of the information presented and discussed at the medical quality assurance meeting is valuable, it is not centered on a review of data that is measured against benchmarks, for the purposes of a medical QA process. Summary: Of the 16 components listed, there was no evidence provided, or description listed in the Facility's policy on medical quality assurance, that outlined how the collective information derived from the 16 components would be analyzed to determine an overall assessment of medical care at the Facility. A medical QA process should include a mechanism to track, trend, and analyze specific outcome data, that is measured against benchmarks set by professional bodies. There was no indication that the Facility measured outcomes, derived through their medical QA process, against professionally derived benchmarks. Furthermore, the 16 components lists for the Facility's medical QA process mostly assessed medical provider information, and did not reflect assessment of other clinical professionals. Although the medical provider oversees medical care, the delivery of medical care is multidisciplinary, and a medical QA process, in the context of a developmental center, should include an assessment of all aspects of the delivery of	

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		medical care, and outcomes derived from the delivery of medical care, inclusive of all relevant disciplines. <u>Review of the Facility's Mortality Review Process</u> To assess the Facility's mortality review process, the Monitoring Team reviewed related policies, participated in a Facility meeting to review the mortality review process of two individuals who expired during the reporting period, and reviewed the clinical and administrative death review committee meeting minutes for the 18 deaths that occurred during the reporting period. New/Revised Policies, Procedures, Protocols, and Processes: DSSLC Policy Number: CMGMT 01B Exhibit N and Medical – 07, Death of Resident, Date: 4/15/14 is comprehensive, and includes all efforts and responsibilities necessary to complete, following the death of an Individual. The Monitoring Team has concerns over the following components of the policy: • Section 2, sub-section l, the policy indicates that the primary PCP and RN case manager will complete a written death summary. The Monitoring Team is concerned that the medical provider who was responsible for the medical care of the Individual is completing the summary, which will be used as a guide for the external physician who will participate at the mortality review committee meeting, and strongly suggests that the either the Facility's medical director, or preferably an external physician who has expertise in development disabilities, conduct the initial clinical review of the case, and present findings to the mortality review committee. • Section 15, subsection b, did not enable the mortality review committee an opportunity to discuss the death summary, and deliberate on possible factors other than those noted on the death summary. The committee should review all relevant clinical documents, and the death summary, and provide additional insight and comments, when indicated. • The Monitoring Team has serious concerns for Section 15, subsection c, that requires a review of routine, preventive and acute care efforts for the past 12 months. All relevant clinical information should be reviewed, not limited to 12 months. Monitoring Team's Review of Individuals Clinical and Administrative Death Review Committees Meeting Minutes and Required Documentation Associated with the Deaths: The Clinical Death Review Committee membership included, but was not limited to: Medical Director, Staff Physicians/Family Nurse Practitioners, Health Services Compliance Coordinator, External Physician, Chief Nurse Executive, Nursing Operating Officer, Nurse Investigator, Compliance Nurse, RN Case Manager Supervisor, Habilitation	

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		Director, RN Case Manager, Quality Assurance Nurse, Infection Control Nurse, Hospital Liaison Nurse, Staff RN, and other disciplines/program support staff when indicated The Administrative Death Review Committee membership included: 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. Monitoring Team's Independent Review of Deaths: Since January 2014, 18 deaths had occurred. Clinical and Administrative Death Review Committee Meetings were completed for 17 deaths, with one death review still in process. General findings of the 18 deaths reviewed included: • Of the 18 deaths reviewed, the average age was 59 years (ages varied from 42 to 79 years of age). • Zero of 18 (0%) deaths had an autopsy completed. • Thirteen of 18 (72%) decedents received enteral nutrition via G-Tube feedings. • Two of 18 (11%) were reported as unusual deaths. • Eighteen of 18 (100%) had Unusual Incident Reports (UIRs) completed related to the deaths. • Twelve (67%) occurred at a hospital. Six deaths (33%) occurred at the Facility. • Eighteen of 18 (100%) 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. • The cause of 18 individuals' deaths, as listed on the Death Certificates, are listed in the chart below: 1. Individual #573: Immediate Cause of Death: Intracranial Hemorrhage Medulla, Pons, Cerebellum Secondary Cause of Death: Pneumonia Underlying Cause of Death: Influenza 2. Individual #211: Immediate Cause of Death: CVA Secondary Cause of Death: Respiratory Arrest Underlying Cause of Death: Shock 3. Individual #: 341 Immediate Cause of Death: CHF (Congestive Heart Failure) Underlying Causes of Death: COPD (Chronic Obstructive Lung Disease) 4. Individual #719:	

#	Provision	Assessment of Status	Compliance
		Immediate Cause of Death: Protracted Seizure for Two Hours Secondary Cause of Death: Brain Anoxia Underlying Causes of Death: Cardiac Arrest and Multiorgan Failure	
		5. Individual #: #423 Immediate Cause of Death: Pneumonia Secondary Cause of Death: Respiratory Failure Underlying Causes of Death: Heart Disease	
		6. Individual #: #136 Immediate Cause of Death: Malrotation of Bowel with Obstruction Secondary Cause of Death: Cardiac Arrest Underlying Causes of Death: Respiratory Arrest	
		7. Individual #: #606 Immediate Cause of Death: Influenza Secondary Cause of Death: Pneumonia Underlying Causes of Death: Acute and Chronic Aspiration	
		8. Individual #: #187 Immediate Cause of Death: Respiratory Failure Secondary Cause of Death: Renal Failure Underlying Causes of Death: Hypertension	
		9. Individual #: #305 Immediate Cause of Death: Pneumonia Secondary Cause of Death: Acute Renal Failure Underlying Causes of Death: Respiratory Failure	
		10. Individual #: #111 Immediate Cause of Death: Spinal meningitis Secondary Cause of Death: None Listed Underlying Causes of Death: None Listed	
		11. Individual #: #129 Immediate Cause of Death: Central Apnea Secondary Cause of Death: Bronchitis Underlying Causes of Death: Acute Respiratory Failure	
		12. Individual #: #531 Immediate Cause of Death: Aspiration Pneumonia Secondary Cause of Death: Sepsis	

#	Provision	Assessment of Status	Compliance
		Underlying Causes of Death: DKA (Ketoacidosis) 13. Individual #: #242 Immediate Cause of Death: Acute and Chronic Respiratory Failure Secondary Cause of Death: Severe OSA (Obstructive Sleep Apnea) Underlying Causes of Death: 14. Individual #: #336 Immediate Cause of Death: End Stage Lung Disease Secondary Cause of Death: Pneumonia Underlying Causes of Death: None Listed 15. Individual #: #576 Immediate Cause of Death: Respiratory Arrest Secondary Cause of Death: None Listed Underlying Causes of Death: None Listed 16. Individual #: #743 Immediate Cause of Death: Respiratory Failure Secondary Cause of Death: Recurrent Pneumonia Underlying Causes of Death: None Listed 17. Individual #: #760 Immediate Cause of Death: Aspiration Pneumonia Secondary Cause of Death: Sepsis Underlying Causes of Death: None Listed 18. Individual #: #602 No Death Certificate Provided – Facility physician listed cause of death as: Malignant Carcinoid and Metastases to Liver and Lungs • 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 17 of the 18 of deaths reviewed (94%). One death review still in process of being completed. • A review of the Clinical and Administrative Death Review Committees' minutes, and supporting documentation, and Recommendation Tracking Logs for each death showed that recommendations that had been completed for 16 deaths of the 17 due for completion (94%). The recommendations for one recent death were not due for	

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		completion and was in the process of being completed; therefore the recommendations had not been finalized. Although the recommendations were relative to the issues identified in the Clinical and Administration Death Committees' Reports, there were no follow-up actions included to ensure their efficacy. The Facility should consider monitoring the efficacy of recommendations in relation to improving the quality of care for the general population. • The Monitoring Team reviewed the clinical records and available death review committee meeting minutes for Individuals #719 and 760, and determined that the mortality review committee did not assertively review clinical records or develop meaningful action plans. To assist the Facility in further developing its mortality review process, the Monitoring Team provided technical assistance to the Facility and highlighted the necessary details of a mortality review. • Because of the significant number of deaths resulting from pneumonia, and pneumonia related conditions, the Monitoring Team reviewed the Facilities policies and procedures for influenza, and influenza like illness; this review is further delineated in Section L.1, of this report. Furthermore, the Monitoring Team provided technical assistance to the Facility that addressed diagnostic challenges when triaging pneumonia, and influenza. Conclusion: The Monitoring Team compliments the Facility for further developing processes to enhance medical quality assurance and mortality review. The Facility had completed an extraordinary amount of intense work on developing a new policy to address the processes involved following the death of an individual, and further developed its medical QA process by developing several medical quality indicators. During the Monitoring Team's meeting with the medical director, the medical director concurred that the Facility needs to continue to improve its mortality review process, to include a more assertive review of clinical care. Furthermore, the Facility's medical QA process must include outcome data, that can be compared to benchmark data derived from professional bodies, and the process must not only include the assessment of medical provider's assessments, and treatments, but assessments and treatments provided by all relevant disciplines. Because of these issues, the Facility is not in compliance with Section L.3.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care	To determine if the Facility's policies and procedures help ensure that the quality of medical services is at the level of standard of care practice, the Monitoring Team request a copy of the Facility's medical policy and procedure, and a copy of all new and updated policies for medical care. The Facility provided: 1. DSSLC Medical Quality Assurance Policy, Med-01 Exhibit H, dated 7/1/2014 2. DSSLC Death of a Resident Policy, CMGMT 01B Exhibit N and Medical – 07, dated,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	4/15/2014 3. DSSLC Unvaccinated DSSLC Residents Protocol; 05/29/2014 4. DSSLC Wearing and Disposing of Gloves Protocol, undated and un-numbered 5. DSSLC Multidrug Resistant Organisms Policy, Revised 05/08/2014, un-numbered 6. DSSLC Steps to Take When A DSSLC Unit/Apartment Has A Suspected/Confirmed Case of Influenza (Outbreak) protocol, dated 10/24/2014 7. DSSLC Ethics Committee Policy, number 14, dated 5/1/2014 8. DSSLC Integrated Clinical Services Policy #GMGMT 03, dated 12/1/2013 9. DSSLC life threatening Emergency Situations Policy, Medical 06, dated 03/1/2014. Because of time limitations, the Monitoring Team was unable to review all new policies and procedures. The Monitoring Team reviewed the following policies, and procedures in detail, and documented concerns, and comments in Sections L.2, and L3, of this report: 1. DSSLC Medical Quality Assurance Policy, Med-01 Exhibit H, dated 7/1/2014 2. DSSLC Death of a Resident Policy, CMGMT 01B Exhibit N and Medical – 07, dated, 4/15/2014 3. DSSLC Unvaccinated DSSLC Residents Protocol; 05/29/2014 4. DSSLC Wearing and Disposing of Gloves Protocol, undated and un-numbered 5. DSSLC Multidrug Resistant Organisms Policy, Revised 05/08/2014, un-numbered 6. DSSLC Steps to Take When A DSSLC Unit/Apartment Has A Suspected/Confirmed Case of Influenza (Outbreak) protocol, dated 10/24/2014 Conclusion: As delineated in Sections L.2, and L.3, the Monitoring Team determined that many policies did not reflect standard of care practice, such as those for influenza, and infection control precautions, and for this reason, the Facility remains not in substantial compliance with Section L.4. The Monitoring Team, nonetheless, compliments the Facility for its efforts to further develop policies and procedures for its clinical practice.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Section M Self-Assessment, Updated: 7/3/14 2. DSSLC Section M Action Plans, undated 3. DSSLC Section M Presentation Book 4. Department of Aging and Disability Services (DADS), State Supported Living Centers (SSLCs), Nursing Competency Based Training Curriculum Guidelines, Date: March 2014 5. DSSLC Protocol for Unvaccinated DSLC Residents, 5/29/14 6. DSSLC Guidelines for Wearing and Disposing of Gloves, 3/26/14 7. DSSLC Multi-Drug Resistant Organisms (MDRO) Policy, Revised 5/8/14 8. DSSLC Protocol for Steps to Take When a DSSLC Unit/Apartment has a Suspected/Confirmed Case of Influenza (Outbreak), 10/24/13 9. DSSLC Division of Nursing; Infection Control/Employee Health, Reviewed/Revised: 10/22/13 10. DSSLC Pandemic Respiratory Infectious Disease Readiness Plan, Reviewed 10/22/13 11. DSSLC Procedure: Medication Administration Guidelines – Addendum A for DSSLC, Date: December 2013 12. DSSLC PP#02.01.01Exh 3, Med Storage Audit Procedures, Date: 5/16/14 13. DSSLC List of any new Policies addressing the provision of nursing care, no date 14. DSSLC Campus Map 15. DSSLC Nursing Organizational Chart 16. DSSLC Nursing Standardized Procedures-Protocols-Guidelines Tracking Spreadsheet, 7/18/14 17. DSSLC Nursing Education Monthly Summary Reports, January 2014 through June 2014 18. DSSLC Nursing Education/Training Calendar for 2014 19. DSSLC Nursing Monthly Staffing Patterns' Analysis for all Units and Infirmary, December 2013 through June 2014 20. DSSLC Number of Nursing Positions Budgeted, Filled, and Unfilled, to date 21. DSSLC RN Case Manager Roster, 6/3/14 22. DSSLC Nursing Monthly Overtime Hours Report, December 2013 through May 2014 23. DSSLC Nursing Monthly Agency Nurse Hour Reports, December 2013 through May 2014 24. DSSLC Nursing Monthly Schedule for all Units and Infirmary and for all shifts, June 2014 25. DSSLC Nursing Meeting Schedule for the Week of July 21, 2014 26. DSSLC Nursing Unit Meeting Minutes, January 2014 through May 2014 27. DSSLC Nursing Management Meeting Minutes for May 2014 28. DSSLC Registered Nurse (RN) Case Management Staff Meeting Minutes, January 2014 through June 2014 29. DSSLC Nursing Skin Integrity Reports, January 2014 through May 2014 30. DSSLC Physical and Nutritional Management Committee Meeting Minutes, January 2014 through July 2014 31. DSSLC Nursing Compliance Meeting Minutes, January 2014 through June 2014

	32. DSSLC Nursing Assessments Timeliness – by Unit Data Chart, November 2013 through February 2014 33. DSSLC QA/QI Council Meeting Minutes, January 2014 through June 2014 34. DSSLC Monitoring Process: Section M – Nursing, Updated: 6/17/14 35. DSSLC Inter-rater Reliability Meeting with Nurse Managers Meeting Minutes, 3/19/14 and 6/17/14 36. DSSLC Quarterly Pharmacy and Therapeutics Committee Meeting Minutes, January 2014 through June 37. DSSLC Pre-Medication Variance Committee Meeting Minutes, January 2014 through June 2014 38. DSSLC List of Emergency Response Committee Membership 39. DSSLC Emergency Response Committee Meeting Minutes, 3/31/14 and 6/24/14 40. DSSLC Copies of completed Emergency Drill Checklists and accompanying copies of Corrective Actions taken for failed drills, February 2014 through May 2014 41. DSSLC Medical Emergency Drill Response Average Data Chart, March 2013 through February 2013 42. DSSLC Emergency Medical Drills – Percentage of Audits Passed Data Chart, November 2013 through May 2014 43. DSSLC List of Facility Emergency Equipment and Automated External Defibrillators Locations 44. DSSLC List of Staff Responsible for Conducting. Reporting, and Tracking Mock Medical Emergency Drills 45. DSSLC Incident Management Review Team (IMRT) Meeting Notes/Logs, February 2014 through May 2014 46. DSSLC Competency Development and Training (CDT) Course Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) Basic and CPR for Healthcare Providers, Printed 6/12/14 47. DSSLC Monthly Antibiograms, January 2014 through May 2014 48. DSSLC Infection Control Curricula and Training Materials, Infection Control Prevention and Practices SSLC (copyright), 12/23/11 49. DSSLC CDT Course Due/Delinquent List for Infection Control, Printed 6/12/14 50. DSSLC Percentage of Individuals' Current with Flu Vaccinations, to date 51. DSSLC Percentage of Individuals' Current with Tuberculosis (TB) Skin Testing and Follow-up on Individuals With TB Skin Testing Conversion, to date 52. DSSLC Percentage of Employees Current with Flu Vaccinations, to date 53. DSSLC Percentage of Employees Current with Tuberculosis (TB) Skin Testing and Follow-up on Individuals With TB Skin Testing Conversion, to date 54. DSSLC Percentage of Employees Vaccinated with Hepatitis B Series 55. DSSLC List of Infection Control Monitoring Tools, Monitoring Procedure, Accompanying Data Analyses/Interpretations for each Tool, along with Corrective Actions Taken for Identified Deficiencies, January 2014 through May 2014 56. DSSLC Integrated Morning Report Minutes, 7/21/14 through 7/24/14 57. DSSLC Infirmary Admission for the past year 58. DSSLC Facility Health Risk Data for Individuals 59. Sample review of 10 most recent reported Medication Variance Reports for Individuals: #92, #113, #689, #404, #402, #190, #78, #534, #352, and #752 60. 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 12 Individuals: #279, #513,

	#438, #586, #49, #626 #630, #744, #788, #692, #181, and #436 61. Sample review of Community Living Discharge Planning Comprehensive Nursing Assessments and related documentation on four Individuals: #376, #622, #332, and #698 62. Sample review of Integrated Risk Rating Forms (IRRFs), Integrated Health Care Plans (IHCPs), and related documentation on individuals prescribed continuous oxygen for six Individuals: #435, #218, #690, #313, #739, and #170 63. Sample review of Acute Care Plans/IHCPs and related documentation on four individuals' with active decubitus ulcers/skin integrity issues for Individuals: #286, #639, #351, and #371 64. Sample review of Acute Care Plans/IHCPs and related documentation on five recent cases of Urinary Tract Infections for Individuals: #430, #362, #91, #404, and #590 65. Sample review of Acute Care Plans/IHCPs and related documentation on five reportable Infectious/Communicable Diseases cases for Individuals: #298, #279, #218 (had 2 reportable infectious/communicable diseases), and #517 66. Sample review of five recent hospitalized individuals' records and related documentation for Individuals: #551, #279, #520, #642, and #92 67. Sample review of five seizure records and related documentation on individuals who had recent seizure episodes for Individuals: #411, #781, #126, #772, and #282 68. Sample review of four completed Universal Monitoring Forms for PNM compliance and effectiveness of medication administration practices for Individuals: #760, #463, #351, and #690 69. Sample review of six IRRFs and IHCPs for evidence that individuals' requirement for continuous and/or intermittent oxygen was addressed for Individuals: #435, #218, #690, #513, #739, and #170 **People Interviewed:** 1. Delia Schilder, RN, Chief Nurse Executive (CNE) 2. Sherri Courtney, RN, Nursing Operations Officer (NOO) 3. Sibylle Graviett, RN, Compliance RN 4. Diane Porter, RN, RN Case Manager Supervisor 5. Sharon Lancaster, RN, Hospital Liaison Nurse 6. Amber Shotts, RN, Hospital Liaison Nurse 7. Calista Aston, RN, Skin Integrity Nurse/Wound Care/Educator 8. Maria Palenzuela, RN, Infection Control Preventionist (ICP) 9. Linda Barnett, RN, Nurse Educator 10. Susan Hyde, RN, Nurse Manager, Cedar Falls/Houston Park 11. Traci Carroll, RN, Nurse Manager, Infirmary 12. Laura Binnon, RN, Nurse Manager, Garden Ridge/Westridge 13. Elizabeth Ward, RN, Nurse Manager, 10-6 Shift 14. Numerous Other RN Case Managers, RN, and LVN Staff Nurses **Meetings Attended/Observations:** 1. Review of Section M Presentation with Nursing Leadership throughout the week of the compliance visit 2. Medication Variance Meeting, 7/21/14 3. Review of Red Folders for Deaths, 7/21/14 4. Early Morning Medication Administration Observations and Tour in Houston Park, 7/22/14

	5. Pharmacy and Therapeutics Committee Meeting, 7/22/14 6. ISP Meeting for Individual #280, 7/22/14 7. Meeting Regarding Infection/Influenza Practices, 7/22/14 8. Integrated Morning Report, 7/23/14 and 7/24/14 9. Meeting to Review Facility's Mortality Action Plan, 7/23/14 10. Late Evening Medication Administration Observations and Tour in Garden Ridge, 7/23/14 11. Meeting with Emergency Response Lead Staff, 7/23/14 12. Unit Skin Care Observations with Skin Integrity Nurse, 7/23/14 and 7/24/14 13. Physical, Nutritional, and Management Committee (PNMC) Meeting, 7/24/14 14. Daily Meetings with Various Nursing Leadership
	Facility Self-Assessment: For Section M, in conducting its Self-Assessment, the Facility: • Used the statewide Facility Self-Assessment Monitoring Tools. The monitoring/audit tools the Facility used to conduct its Self-Assessment included: Data analyses of nursing vacancies and staffing levels nursing over time and agency nursing hours, infection control, skin integrity, emergency response, nursing monitoring tools, medication variances, along with narrative explanations for items assessed for each Provision. These data provided sufficient indicators to allow the Facility to determine the status of compliance with the Settlement Agreement. • The data reported included sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment identified the sample(s) sizes. • The monitoring/audit data used in the Self-Assessment had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing and/or reviewing the audit tools: The Chief Nurse Executive, Nursing Operations Officer, Compliance Nurse, RN Nurse Case Manager Supervisor, Specialty Nurses, Nurse Managers, and Quality Assurance Nurse. • The staff responsible for conducting the audits/monitoring were considered competent in the use of the tools and were programmatically competent in their relevant area(s). • The Inter-rater reliability process had been established for all of the nursing monitoring audit tools including the Medication Administration Observation Tool. • 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 nursing assessments, percent of nurses who had completed training classes, infection control reports, number of pressure ulcers, and medication variance data. • The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress. The indicators clearly identified what was being measured or the criteria used for measurement. o Consistently measured the quality as well as presence of items.

	○ Distinguished data collected by the QA Department versus the Nursing Department. • The Facility's Section M Action Plans showed actions that had been taken with the dates of completion and actions that were still in process with projected completion dates that would move the section toward substantial compliance. • The Facility's Self-Assessment stated they were not in compliance with Provisions M.1, M.2, M.3 and M.5 and were in substantial compliance with Provisions M.4, and M.6. The Monitoring Team concurs with their findings for Provisions M.1, M.3, and M.5. The Monitoring Team found substantial compliance with M.2, M.4, and M.6. The Monitoring Team's review of Provision M.2 was not consistent with the Facility's findings that stated it was not in substantial compliance.
	Summary of Monitor's Assessment: Based on the Monitoring Team's review, Provisions M.2, M.4 and M.6 were found in substantial compliance. Provisions M.1, M.3 and M.5 were not found in substantial compliance. The positive nursing practices identified in previous reports for this Section continued to be maintained and strengthened. Significant improvement was found in Provision M.2 regarding compliance with the requirements identified in the Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. Although the Facility Self-Assessment did not find this Provision in substantial compliance, the Monitoring Team's review of the 12 most recent completed admission, annual and quarterly assessments found they were completed timely greater than 85% of the time. The required nursing assessment items contained on the 12 nursing assessment forms were completed thoroughly and reflected good quality. Provision M.3 and M.5 showed the least amount of improvement. However, action plans were in place that should continue to move these Provisions forward toward substantial compliance. Provision M.1 contains 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. The Skin Integrity system showed significant improvement. Over the past six months the data showed a reduction in the incidences of pressure wounds. The required Nursing Administrative, Management and Specialty Nursing staffs consistently attended the Integrated Morning Report. This meeting appeared to have enhanced communication and integration of services across all clinical disciplines. None of Nursing Protocol Card Monitoring Tools had consistently achieved an overall compliance score of 85% over an extended period of time. The Inter-rater Reliability Checks were completed for all Nursing Monitoring/Audit Tools with a consistent overall level of 80% agreement between the Nursing Monitors/Auditors and the Quality Assurance Nurse. Provision M.2 showed significant improvement in the timeliness and quality of nursing assessments completed according to the Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. Therefore, Provision M.2 was found in substantial compliance. Although the Facility Self-Assessment did not find this Provision in substantial compliance, the Monitoring Team's review of the 12 most recent completed admission, annual and quarterly assessments were completed timely greater than 85% of the time. The required nursing assessment items contained on the 12 nursing assessment forms were completed thoroughly and reflected good quality for an overall compliance rating of 91%. Therefore, this Provision was determined to be in substantial compliance.

	Provision M.3 showed the Nursing Department continued to make efforts toward improving the individualization and quality of the Acute Care Plans, but no appreciable improvement was found in the individualization and quality of the Acute Care Plans. Acute Care Plans were often not initiated for acute temporary changes in health conditions, for which plans should have been developed. However, the related documentation for temporary acute changes for health conditions showed consistent assessment/monitoring, and documentation according to relevant nursing protocols. Often for these acute changes in health conditions were followed through "Nurse Watch" as opposed to developing an Acute Care Plan. Provisions M.4 showed continued substantial compliance. The Nurse Educators continued to maintain 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 reviewed that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed. Provision M.5 showed the Facility continued to make efforts toward improving the ISP, Integrated Risk Rating Form, and Integrated Health Care Plan processes. The Facility recently formed a work group to address participation in the ISP, IRRF, and IHCP processes. These processes were continuing to evolve but had not matured sufficiently to demonstrate substantial compliance. 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 a 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.

#	Provision	Assessment of Status	Compliance
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> 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 toward achieving compliance in all of the various requirements contained in this Provision. The Monitoring Team's compliance review findings for this Provision were consistent with the Facility's Self-Assessment of activities engaged in to conduct and report the results of the self-assessment. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. <u>Staffing:</u> At the time of the compliance review, DSSLC had a census of 458 individuals. Since the last compliance review, DSSLC had a total budget for of 220.3 nursing positions, of which 132.3 were RN positions and 88 were LVNs. Vacancy rates for the Nursing Department was reported as varying from a high of 17.7% in May 2014 to a low of 14.01% in January 2014. The Nursing Department continued to address recruitment and retention through a variety of approaches, including Job Fair and advertisement in the Texas Nurses Association Quarterly Publications. 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, , two Nurse Educators, two Hospital Liaison Nurses, and an Infection Control Preventionist. Recently an additional position was made available for an Assistant Infection Control Preventionist, which was being recruited. Two Unit Nurse Managers had resigned. Several applicants had applied and will be interviewed and selected after the compliance review. One Nurse Manager was on extended sick leave. The Monitoring Team's review of monthly Nursing Staffing Pattern Analyses, December 2013 through May 2014 showed the Nursing Department continued to monitor nursing staffing patterns and established nursing ratios for the Units and Infirmary daily on each shift. Staffing levels were reviewed daily prior to each shift by House Nurse Supervisors. In addition, the Nurse Managers continued to meet daily with the 6-2 shift House Nurse Supervisor to review staffing and assist with covering Units when needed by sending nurses from over-covered areas to areas of need. The Nursing Department continued the use of overtime and agency nurses to supplement staffing as needed. During this reporting period staffing patterns did not fall below the minimum requirements. 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,	

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		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. <u>Quality Assurance Efforts:</u> 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 distributed on 3/19/13 in a scan call. There was no change in the monitoring tools used since January 2014. Samples of the records selected for monitoring were generated randomly by the Quality Assurance Department. The QA Nurse completed the monitoring and inter-rater reliability checks on the tools assigned by the Quality Assurance Department. The results of the tools monitored by the QA Nurse were combined with the tools completed by the Nurse Managers and were reflected in the data of the tools. Since January 2014 the QA Nurse conducted inter-rater reliability checks on all nursing monitoring tools. The QA Nurse provided copies of the completed tools to the Compliance Nurse. After review of the tools and/or data the Compliance Nurse conducted meetings with the Nurse Managers and other appropriate Nursing Administrative/Management staff to discuss the outcomes of the monitoring tools. The Compliance Nurse reviewed and updated data presented at the monthly QA/QI Council Meetings. Selected monitoring tools were presented each month. The QI/QA reports provided the overall average percentage of compliance for each tool. In addition, a percentage of compliance was provided for each item on the monitoring tools along with a narrative explanation of the items on the tools that fell below the current standard for compliance of 85%. The Nursing Department included a narrative explanation and corrective actions taken to improve compliance. The Nursing Department did not have any outstanding Corrective Action Plans (CAPs) at the time of the compliance review. According to interviews with the CNE and Compliance Nurse and review of the QA/QA Council reports there were no active CAPs for nursing. Further, there were no reports regarding nursing CAPs that were resolved. The chart below shows the Facility's Self-Assessment overall average percentage for nursing monitoring tool results from the previous quarter. Nursing Monitor Tools: January 2014 Antibiotic Therapy: 74%	

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PICA Episodes	78%
Pre- Treatment and Post-Sedation	74%
Respiratory Distress	72%
Seizure Activity	70%
Status Epilepticus	74%
Urinary Tract Infections	87%
Vomiting	83%
Urgent Care/ER Visits/Hospitalizations	80%
Nursing Care Plans	76.8%

None of the nursing monitoring tools met the current standard for compliance of 85%. As reported in the Compliance Nurse meeting with the Nurse Managers and other Administrative/Management meetings, continuing corrective action was taken either on the spot or during nursing meetings for local deficiencies to improve compliance with the monitoring tools. Unless there were systemic trends identified on the monitoring tools there were no CAPs initiated. In order to achieve substantial compliance with the monitoring tools the standard compliance score of 85% must be met and sustained. Although overall 85% compliance was not achieved with any of the monitoring tools, the Nursing Administrative/Management staff reported there were no systemic trends identified on any of the monitoring tools that would require CAPs. This was an improvement from the last compliance review where there were several outstanding CAPs, of which all had been cleared.

<u>Integrated Morning Report:</u>
The Facility continued to conduct the Integrated Morning Report meetings daily five days per week during business days. The Medical Director chaired the meeting. It was an integrated meeting with staff from medical and nursing services, as well as from other clinical disciplines. There was a standard agenda and format used to conduct the meetings, which included:

- Provider On-Call Report
- Infirmary Report
- Hospital Report
- Specific Departmental/Discipline Report (with specific reports on Tuesdays, Wednesdays, and Thursdays, such as Admissions and Transitions report each Wednesday—some are weekly, some were scheduled on alternate or every third week)
- Follow-Up Items: Individual
- Follow-Up Items: Systemic (Wednesday, and more often as needed)
- Additional Information Discussed

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		A scribe recorded minutes of Integrated Morning Meetings. The disciplines that gave oral reports also provided the scribe copies of their report notes to include in the minutes. The minutes of the reports followed the agenda for topics discussed and included topics that needed follow up actions by the respective disciplines. The minutes included reports on follow up actions taken for topics previously identified as issues. The minutes continue to record these actions through to resolution. The Monitoring Team attended the Integrated Morning Reports on 7/23/14 and 7/24/14 and reviewed the Integrated Morning Report Meeting minutes for 7/21/14 through 7/24/14. The Monitoring Team reviewed the RN Case Manager Supervisor's follow up notes for these dates, which showed she consistently sent the RN Case Managers and other relevant disciplines updated reports with recommendations for Change of Status (CoS) meetings for individuals requiring such meetings. Additionally, the notes showed that the RN Case Manager Supervisor notified and provided information to the RN Case Managers, other nursing staff, and relevant disciplines on issues that required follow up actions. For example: • The note for 7/22/14 showed the RN Case Manager Supervisor notified the RN Case Managers and IDT of Individual #351's hospital discharge on 7/21/4 with a diagnosis of aspiration pneumonia. She informed them of the need to schedule a post hospital planning meeting. • The note for 7/22/14 showed that the Infirmary nurses were informed to trim Individual #551's fingernails to prevent injury. • The note for 7/24/14 stated there was no need of a CoS meeting for Individual #583 as a result of a gluteal cleft wound because this was an ongoing issue that the IDT continued to monitor and address. The wound was most likely caused during check and change of incontinent briefs with the tension applied to the gluteal area. The Skin Integrity Nurse needed to retrain the staff on wound care and the prevention of applying tension to the gluteal area when checking and changing incontinent briefs. Refer to Section G for additional information regarding the Integrated Morning Meetings. <u>Areas of Nursing Documentation that Need Continued Improvement:</u> • Documentation errors were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed. • Continuation nurses notes did not consistently carry over the dates and/or times to the next page. • The time and/or dates of entries into the Integrated Progress Notes were not consistently included. Military time was not consistently used as required for nursing entries. • 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	

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		care professionals were trained on the plans. • The legibility of the nurses' handwriting had somewhat improved but there was continued need for nurses improve the legibility of their notes, signatures, and titles. <u>Availability of Pertinent Medical Records:</u> • Records were made available onsite without difficulty or delay. • The Red Care Plan Books were located in each home. The books were subdivided into four sections per individual: The Integrated Direct Support Professional Care Plans, Acute Care Plans, Integrate Health Care Plans, and the medication sheet instructions. This allowed the Direct Care Professionals (DSPs), floor nurses, and RN Case Managers to have ready access to these documents. <u>Hospital Liaison Nurses' Activities:</u> The Monitoring Team independently verified the activities below through interviews with Hospital Liaison Nurses, attendance at the Integrated Morning Report (IMR) Meetings on 7/23/14 and 7/24/14, and review of the Integrated Morning Report Meeting minutes 7/21/14 through 7/24/14, as well as a review of records for five recently hospitalized Individuals. The Hospital Liaison Nurses continued to perform the positive practices found in previous compliance reviews. In addition to the previous activities reported the Hospital Liaison Nurse performed the following new and/or changed activities: • Continued to strengthen relationships with the local hospital and the long term acute care facility. They reported more involvement with additional disciplines at the hospital's Emergency Room, Gastrointestinal, Respiratory, Physical Therapy, Occupational Therapy, Dietary, and Speech Therapy Departments. As a result they gave an example of an individual (name not provided) who had developed a wound on the back of the neck while hospitalized from a tracheostomy mask tie being too tight. They were able to work with the hospital's Respiratory Department and showed them the protective sleeve used at the Facility to prevent this type of injury. Consequently, the hospital ordered the same sleeve and the hospital now uses it for their patients who required the use of tracheostomy masks. Additionally, the Hospital Liaison Nurses continued to develop more in depth interactions with the hospital's Hospitalists, Pulmonologist, and Infection Disease Specialist, who see the DSSLC individuals and follow them at the long term acute care facility. These efforts were reported to have greatly improved the continuity of care for individuals throughout their hospitalization. • New relationships have been established with the hospital's Information Management Department. The Hospital Liaison Nurses were now able to get copies of Emergency Medical Services (EMS) reports regarding the care individuals received in route to the hospital if needed to provide more information and	

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		clarification of records. • Continued to have access to the local hospital personnel that allowed the Hospital Liaison Nurses to check on hospitalized individuals on the weekends and over long holidays. The CNE arranged with the hospital to have dedicated personnel available to contact over such periods. In addition, the hospital was provided with the numbers for the Infirmary and Campus Nurses should the hospital need to contact the Facility over weekends and long holidays. • For all death reviews, one of the Hospital Liaison Nurses was available for consultation with the primary care providers (PCPs) to assist with completing the death reviews in order to gain a better overall picture of individuals' hospitalization course prior to and leading up to their deaths. When consulting with the PCPs the Hospital Liaison Nurses ensured all paperwork was provided to the meetings. This enabled them to have the necessary information available to the PCP to discuss, answer questions, and to obtain additional information when needed. Reportedly, this had proved to expedite and improve the death review process. • Attended the Compliance Nurse Meetings to review/discuss the use of the monitoring tool for hospitalization and the completed audits. This has enabled the Nursing Administration/Management staff to identify problematic issues and to take corrective action to improve compliance with the audits. The Hospital Liaison Nurses identified issues with the required hospitalization documentation not being placed into the active record by the Record Clerks in a timely manner, which was due in part to the overwhelming amount of paperwork sent to them for filing. This caused the nurse auditor to find a lack of compliance with some items required on the monitoring tool. Consequently, the Hospital Liaison Nurses began filing hospitalization documentation directly into individuals' records when records were in the Infirmary. Hospitalization documentation was also scanned into individuals' electronic records. When the active records were not available for filing, the hospitalization documentation was sent directly to the Record Clerks in medical records to file so fewer staff were handing the paperwork as well as to ensure that the information was consistently filed. Additionally, the nurse auditor was instructed when monitoring to also look in individuals' electronic records to ensure that all required hospitalization documentation was audited. This appeared to have improved compliance with the hospitalization audits. <u>Monitoring Team's Independent Review of Recent Hospitalized Individuals:</u> The Monitoring Team reviewed a sample of five recently hospitalized individuals' records and related documentation for Individuals: #551, #279, #520, #642, and #92. Findings included: • Five of five (100%) records showed a nurse or clinic staff or provider documented an assessment in the Integrated Progress Notes (IPNs) prior to the transfer to the	

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		hospital describing circumstances of incident, need to transfer, findings of assessment, and notification of Primary Care Providers (PCPs). • Five of five (100%) records showed the Hospital Transfer Forms were completed as required by policy and protocol. • Five of five (100%) records showed pre-transfer diagnoses were written in the IPN or Physician's Order. • Five of five (100%) records showed the date, time, and method of transfer was included in the IPNs or Physician's Orders. • Five of five (100%) records showed, if an individual was admitted to the hospital, that the Hospital Liaison Report progress notes included current diagnoses of individual's problem, type of treatment received, clinical status during visitation/contact, and any discharge planning, including any special services/supports needed. • Five of five (100%) records showed documentation on the Hospital Liaison Report and/or the INPs that the Hospital Liaison Nurse had visited or made telephone contact to the individual in the hospital daily during business days. • Five of five (100%) records showed upon discharge from the hospital a completed nursing assessment (RN Post Hospital Assessment Form) was performed by an RN within two hours, including subjective information, a full set of vital signs with oxygen saturation level, physical assessment, including a skin assessment, a nursing analysis of problem/diagnosis as per assessment findings. • Zero of three (0%) records showed that there was documentation of nursing assessments and IPNs completed at the frequency indicated by the individuals' Acute Care Plan and/or Change of Status (CoS) or Integrated Health Care Plans (IHCPs). Two of the five individuals did not require care plans. For example: Individual #279 was discharged and returned home, but was immediately sent back to the hospital for further evaluation and treatment. When Individual #520 was next discharged from the hospital he was placed on hospice and care was provided according to hospice care protocol. Due to the lack of Acute Care Plans and/or IHCPs for three individuals, it was not possible to determine whether the documentation of nursing assessments and IPNs were completed at the frequency that would have been indicated if they had such plans. • Zero of three (0%) records showed a PNMT Nurse Post Hospital Assessments/Evaluations completed due to hospitalization for pneumonia and/or skin integrity issues. The two individuals would not have required PNMT Nurse Post Hospital Assessments/Evaluations due to the reasons stated in the above examples. A review of the above records showed most of the compliance requirements were met regarding the Urgent Care/ER/Hospitalization Policy and Protocol, but there was lack of documentation found showing compliance with completing PNMT Nurse Post Hospital	

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		Assessments/Evaluations and Acute Care Plans and/or Change of Status (CoS) revisions to the IHCPs for those individuals who should have had such assessments and care plans as a result of their hospitalization. The Nursing Department should continue to ensure that all aspects of the Urgent Care/ER/Hospitalization Policy and Protocol are consistently followed. <u>Skin Integrity Nurse Activities:</u> The Monitoring Team's independent interview and review of documents found that the certified Skin Integrity Nurse had continued to maintain the positive practices identified at the last compliance review and had continued make progress in improving the organization, management, and training for skin integrity/decubitus ulcer care, as well as tracking, analyzing, and trending skin integrity/decubitus data, and then developing and implementing corrective actions plans to improve the quality and management of skin integrity/decubitus ulcer care. The following summary describes the new/additional activities performed by the Skin Integrity Nurse conducted over the past six months: • Taught basic wound care and documentation at New Employee Orientation classes for nurses. The training instructed the nurses in how to recognize suspected signs of pressure to the skin, and what to refer to the PCP and Skin Integrity Nurse. Prepared and presented in training a slide presentation for performing wound dressing changes to prevent causing infection and cross contamination. • Prepared a personal packaged set-up of all necessary wound care supplies for each individual with wounds that required dressing changes. The set-up includes a personal pair of bandage scissors to further prevent cross-contamination of wounds. This ensures that all necessary supplies were available to the nurses changing dressings. • Created a wound care supply list with par levels in order to ensure that supplies were always available, particularly afterhours, weekends, and holidays. • Developed and implemented a Skin Integrity Acute Care Plan template and put it in the share drive in order to make it available for nurses to use as a guide when developing such care plans. • Enhanced collaboration with the Facility's Hospital Liaison Nurses, Habilitation Department disciplines, and IDTs to identify and manage care of individuals with skin integrity issues. Also worked collaboratively with the Infection Control Preventionist to ensure infection control measures were followed to treat and/or prevent skin integrity infections. During the last six months the Skin Integrity Nurse had completed wound care and dressing changes with the Infection Control Preventionist to ensure infection control measures were carried out to prevent cross-contamination. • Enhanced collaboration with the hospital wound care nurse when individuals with increase skin integrity risk were hospitalized. The hospital wound care nurse was	

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		provided reports of their skin integrity histories as well as any current issues. • Continued to attend all individuals' appointments with the Wound Care Specialist at the Baylor Medical Center to reduce the loss of important information in translation and to gain more knowledge regarding wound care management of individuals. • A Physical Therapist was in the process of being teamed up with the Skin Integrity Nurse to assist with pressure wound assessments and the development of integrated plans of care. The Physical Therapist will also be able to attend individuals' appointments to the comprehensive wound care clinic when indicated. This will be of great help with positioning and prevention. The Physical Therapist will be able to do some skin debridement on campus. The long term goal was to create a wound care team at the Facility that would include all relevant disciplines. Combining relevant disciplines will provide a more comprehensive review and management of skin integrity issues and pressure wound care. • Performed and prepared monthly analysis and summary reports by unit for the number of reportable skin integrity injuries and pressure wounds with accompanying narrative reports describing the individuals affected, dates of their diagnoses, stage of pressure wounds, location of pressure wounds, treatments provided, and dates pressure wounds were resolved. The narrative also described whether pressure wounds were Facility or hospital acquired. These reports were provided, reviewed, and discussed for further dispensation at the PNMT and quarterly PNMC meetings. This information was sent to the Quality Assurance Department who provided skin integrity data reports at the QA/QI Council meetings. This information was reviewed and discussed for further dispensation as part of Nursing's Section M clinical key indicators. • Attended IDT and ISP/ISPA meetings to report, discuss, and elicit additional recommendations from other disciplines regarding care of individuals with current and/or history of skin integrity issues. Also attended the Morning Medical Reports and provided skin integrity reports when applicable and followed up on any reported skin integrity issues reported on individuals in the hospital and/or Facility as applicable. <u>Skin Integrity Reports for last six month of 2013 and the first six months of 2014:</u> The Monitoring Team independently reviewed and compared skin integrity data from the last six months of 2013 to the first six months of 2014 and found a considerable decrease in the number of reportable injuries and pressure wounds. A comparison of the incidence rate of pressure wounds between the 2013 data and the 2014 data showed an overall average decrease of approximately 30% in the incidence rates of pressure wounds. The decrease in incidence rates can most likely be attributed to the enhanced collaboration/integration between the Facility disciplines, as well as with hospital disciplines. The charts below show skin integrity data mentioned above.	

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Year: 2013

Month	July	August	September	October	November	December
# reportable injuries acquired for month	12	14	9	3	3	4
# individuals with pressure wounds for the month	7	6	5	3	3	3
Census on last day of month	483	483	481	497	477	475
# days in the period	31	31	30	31	30	31
*Incidence rate for pressure wounds	0.47%	0.40%	0.35%	0.20%	0.21%	0.20%

*Incident rate = # individuals with pressure ulcers divided by census x # days x 1000 (for 1000 patient bed days)

Year: 2014

Month	January	February	March	April	May	June
# reportable injuries acquired for month	3	2	1	0	6	2
# individuals with pressure wounds for the month	3	2	1	0	5	2
Census n last day of month	463	461	460	460	461	460
# days in the period	31	28	31	30	31	30
*Incidence rate for pressure wounds	0.21%	0.15%	0.07%	0.00%	0.35%	0.14%

*Incident rate = # individuals with pressure ulcers divided by census x # days x 100 (for 1000 patient bed days)

<u>Monitoring Team's Independent Review/Observation of Individuals with Recent/Active Pressure Wounds:</u>

At the time of the compliance review, there were three individuals with active pressure wounds, of which two were stage IV and one was a deep tissue injury. One of the stage IV pressure wounds to the coccyx was hospital acquired and the other stage IV pressure

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		wound to the left popliteal fossa was Facility acquired. The deep tissue wound to the left heel was Facility acquired. During the onsite visit the Monitoring Team accompanied the Skin Integrity Nurse and observed her assess and change the dressings on Individuals #286, #639, and #371. The Skin Integrity Nurse completed a thorough assessment of the size, depth, appearance, and stage of wound healing and performed the dressing changes according to generally accepted standard of practice for clean technique. This showed significant improvement in the Skin Integrity Nurse's technique observed at the last compliance review. Refer to Provision M.3 for reports on Skin Integrity Acute Care Plans (ACPs) and related documentation. Refer to Provision M.3 for reports on Skin Integrity Acute Care Plans and accompanying documentation. <u>Infection Control Preventionist Activities:</u> The Infection Control 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: <u>New and/or Revised Infection Control Policies, Procedures, Protocols, Processes and/or other documents addressing Infection Control:</u> • DSSLC Protocol for Unvaccinated DSSLC Residents, 5/29/14 • DSSLC Guidelines for Wearing and Disposing of Gloves, 3/16/14 • DSSC MDRO Policy, Revised: 5/8/14 • DSSLC Steps to take When a DSSLC Unit/Apartment has a Suspected/Confirmed Case of Influenza (Outbreak), 10/24/13 <u>Infection Control Training Activities by the Infection Control Preventionist:</u> • 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 6/12/14, for Infection Control annual refresher training showed that 37 employees were due/delinquent on this training. 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 Infection	

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		Control Training to prevent the spread of infections. • Training was provided to units/home when there were specific outbreaks of infections: o On 5/21/14, Cedar Falls Unit, Apartment 512 C staff were trained on infection control measures for an individual with a Legionella infection. o On 6/2/14, Cedar Falls Unit, Apartment 512 C staff were trained on infection control measures to take for an individual with a Clostridium difficile infection. o On 7/15/14, the Cedar Falls Unit, Apartment 512 C staff were trained on infection control measures to take for an individual with a MRSA infection. o On 7/23/14, the Houston Park Unit, Apartment 515A staff were trained on infection control measure for an individual with a potential Mumps infection. <u>Physical Nutritional Management Committee (PNMC) Meetings Data Reports:</u> 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. As reported below, the Infection Control Preventionist also reported the results of monitoring. <u>Infection Control Monitoring Activities:</u> The Infection Control Preventionist reported on the following 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. • The above monitoring data were tracked, analyzed, trended, with corrective actions taken on identified deficiencies as needed. This information was presented quarterly and/or more often when indicated to the PNMC for further review and disposition. New cases of pneumonia were presented and discussed weekly at the Incident Management Review Team meetings. Monthly reports on clinical indicators for all infections were presented at the QA/QI Council meetings for review and disposition, including aspiration pneumonia and pneumonias. This information was verified through the Monitoring Team's independent interview with the Infection Control	

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		Preventionist, review of supporting documentation provided in the document request, review of PNMC and QI/QA Council Meeting minutes, along with accompanying handouts, January 2014 through June 2014. The Monitoring Team attended the PNMC meeting on 7/24/14, but the quarterly infection data was not due to be presented. For additional information regarding reports of aspiration pneumonia/pneumonia refer to Section O and Section L of the report. • Continued to maintain monthly infection data in the AVATAR database by number, type, and location of occurrence. Infection Data was analyzed quarterly by number and incidence rate. The chart below shows the infection data reported for the first quarter of 2014. Infection data for the second quarter was not yet analyzed and reported.	

First Quarter 2014 Infection Data

Month	Respiratory	Conjunctivitis	Aspiration Pneumonia	Other Pneumonia	Pseudomonas	Urinary Tract Infections	Skin and Soft Tissue Injuries	Clostridium difficile	Vancomycin Resistant Enterococci	Methicillin Resistant Staphylococcu
# Infections	32	17	1	50	7	55	64	64	1	7
Average Census for last day of month	461	461	461	461	461	461	461	461	461	461
Average # Days in period	30	30	30	30	30	30	30	30	30	30
Incidence rate	0.77%	0.35%	0.07%	1.53%	0.7%	1.88%	1.81%	0.07%	0.00%	0.14%

- The Infection Control Preventionist Nurse continued to prepare and distribute monthly Antibiogram and Epidemiology Reports to the primary care providers on appropriate usage of antimicrobial agents.
- For 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.
- For 2014 there was a 99.5% compliance rate for employees receiving annual TB skin testing. Conversion rate was 0.2% TB skin tests. Three individuals had chest x-rays completed with negative results and completed TB questionnaires.
- For 2013-2014 flu seasons, there was a 99.3% compliance rate for individuals receiving influenza vaccinations.
- For 2013-2014 flu seasons, there was a 49.1% compliance rate for employees

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		receiving influenza vaccinations. • Currently 51% 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. They were also given the Hepatitis B Declination Form and were asked to explain the reason they choose to decline the vaccines. 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 were a standalone Provision, it would continue to be considered in substantial compliance. <u>Monitoring Team's Independent Review of Medical Emergency Drills and Emergency Response Activities:</u> 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: • 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. • 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. • 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: 96% in January 2014, 97% in February 2014, 94% in March 2014, 97% in April 2014, and 91% in May 2014. The Nurse Managers and/or nurse designee reviewed the completed the emergency equipment daily checklists. They took real time corrective action with the appropriate nursing staff if issues with the emergency equipment were identified. • The Security Specialist continued to schedule, track, analyze, and provide completed Mock Medical Emergency Drills Reports to the Quality Assurance Department. Mock	

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		Medical Emergency Drills continued to be completed according to the frequency required by policy and schedule. The monthly drill data for the overall percentage of completed and passed drills, January 2014 through June 2014, are shown in the chart below.	

January 2014	February 2014	March 2014	April 2014	May 2014	June2014
94%	94%	100%	97%	100%	100%

- The next working day after drills were completed, the results of the drills were reported to IMRT for review and disposition. The Monitoring Team reviewed a sample of the IMRT Notes for which the drills were reported, February 2014 through May 2014, and found if there were issues identified by the IMRT the minutes reflected the recommendations made in the notes. The notes during the period reviewed showed any issues with performance were corrected on the spot and no further corrective actions were recommended. This showed improvement from the last compliance review where several corrective actions were taken and followed through to resolution. According to the 7/22/14, QA/QA Council Meeting minutes there were no CAPs required during this reporting period.
- 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.
- The Competency Development and Training (CDT) Due/Delinquent Training List, printed 6/12/14, for Cardiopulmonary Resuscitation (CPR) Basic showed 11 employees were delinquent. CPR for Health Care Providers showed two employees were delinquent. This showed a decrease in the number of employees who were delinquent in refresher training since the last compliance review. It is essential that the Facility continue to ensure that all employees are current with their respective CPR training.
- On 7/23/14, the Monitoring Team's met with key Emergency Response Committee members and discussed any significant change that had occurred since the last compliance review. The group stated additional scenarios were used during the drill to enact potential emergency situation, including a drill of rescuing a victim in a bathtub. The issues of an empty oxygen tank found during the 3/28/14 regulatory visit was discussed. It was explained that the oxygen tank in question was a spare tank that was not part of the emergency equipment. However, the spare oxygen tanks were not checked daily as were the oxygen tanks that were part of the emergency equipment. The plan of correction was discussed and actions taken. The corrective action taken included: Training the staff in units/home that have spare oxygen tanks to remove empty tanks into designated storage rooms so that an empty oxygen tank could not be accidently obtained. They developed and implemented a monthly Spare Oxygen Checklist, which was placed in Medication Administration

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		Notebooks on each unit/home. They required the nursing staff to check the pounds per square inch (PSI) of pressure in the spare oxygen tanks daily when checking the emergency equipment. This practice was verified during the Monitoring Team's tour in Houston Park A and B. • The Monitoring Team's independent review of quarterly Emergency Response Committee Meeting minutes, 3/21/14 and 6/24/14, showed the Committee met consistently with all core members in attendance. The Committee continued to review and critique all types of drills performed at the Facility, including Mock Emergency Drills, Code Blue Events, Fire Drills, and Tornado Drills. The results of the Emergency Medical Drills were reviewed and discussed, along with any issues relating to the emergency equipment and automated external defibrillators. • 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. 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. The Nursing Department should continue to focus 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 within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	<u>Monitoring Team Findings:</u> The Monitoring Team verified 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, and 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. Based on the Monitoring Team's independent review of the recently completed nursing assessments, Provision M.2 was found in substantial compliance. <u>New and/or Revised for Nursing Assessment Policies, Procedures, and Guidelines:</u> There were no new/revised nursing assessment related policies, procedures or guidelines reported.	Substantial Compliance

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		Training Activities for RN Case Managers: Refer to Provision M.4 for information on training activities. RN Case Management Activities: Since the last compliance review the RN Case Manager Supervisor had continued the positive practices identified in the last compliance review. Activities reported during the last six months included the following. • The RN Case Manager Supervisor continued to conduct monthly meetings with the RN Case Managers to keep them up to date on issues affecting their areas of responsibilities, to provide additional training, and feedback on areas of practice that needed continuous improvement. These efforts were reported to have resulted in steady and sustained improvement not only in timeliness but also in the quality of the nursing assessments. • In order to promote enhanced communication and integration, the RN Case Managers' offices were physically located in close proximity with other relevant disciplines, i.e., Qualified Intellectual Disability Professionals (QIDP), psychologist, and behavioral analyst. • A focus was placed on "hands on" interaction for the RN Case Managers to enhance care. This expectation was communicated to the RN Case Managers to go out to the homes to see individuals and to monitor and support the nursing and the direct support professional staffs in the delivery of care. • In May 2014, a new process was started with the RN Case Managers conducting quarterly reviews with their respective medical providers and other relevant team members, as indicated. It was reported that this process was working well by both the RN Case Managers and medical providers, which had resulted in more thorough and comprehensive quarterly reviews for both disciplines. • The Change of Status (CoS) and post hospital planning was facilitated by daily updates and follow-up by the RN Case Manager Supervisor with the RN Case Managers regarding IDT meetings and content discussed. The RN Case Manager Supervisor in Coordination with the QIDP Coordinator actively reviewed the CoS plans for quality. • The RN Case Manager Supervisor periodically reviewed the completed action plans and progress for high-risk individuals with the responsible RN Case Manager to ensure quality. Monitoring Team's Review of Recently Completed Comprehensive Nursing Assessments and/or Quarterly Nursing Record Review/Quarterly Physical Assessments: The Monitoring Team independently reviewed the most recently completed Admission, Annual Comprehensive Nursing Assessments or Quarterly Nursing Reviews and Physical Assessments of a sample selected from the Facility's At Risk List for individuals identified	

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		at high risk health conditions from each unit for 12 Individuals: #279, #513, #438, #586, #49, #626, #630, #744, #788, #692, #181, and #436. Finding included the following: • Three of three (100%) Admission Nursing Assessments were completed timely, within 30 days of admission. • Seven of eight (88%) Annual Comprehensive Nursing Assessments were completed timely, at least 10 working days prior to the annual ISP meetings. • One of one (100%) Quarterly Nursing Assessment reviewed was completed by the last day of the month that the quarterly was due. Using a monitoring tool comparable to the tool previously used by the Nursing Department, the review of the 12 most recently completed admission, annual or quarterly nursing assessments found an overall compliance score of 91% compliance with the DADS Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. Greater than 85% of the nursing assessments were completed timely greater than 85% of the time. There were no significant trends of deficiencies found in the required assessment items reviewed. Based on the Monitoring Team's independent review of the most recent nursing assessments, Provision M.2 was found in substantial compliance. This was inconsistent with the Facility's findings of noncompliance. The inconsistency in findings may be attributable to the January 2014 revised Annual Assessment Monitoring Tool that was used to determine compliance. This tool was more generalized and did not include each specific assessment item required by the guidelines or items printed on the nursing assessment forms. The Nursing Department should re-evaluate the revised Annual Nursing Assessment Tool to ensure it is consistent in monitoring all of the specific assessment items included in the guidelines and on the assessment forms. In order to maintain substantial compliance the Nursing Department must continue to maintain the positive practices identified in the above report and continue to take action when deficiencies are identified. Refer to Provision M.5 for report on IRRFs and IHCPs.	
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	<u>Monitoring Team's Findings:</u> The Monitoring Team independently verified 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	Noncompliance

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	conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	M.3 and the Monitoring team concurs with their findings. <u>Nursing Training/Educational Activities:</u> • Refer to Provision M.4 report for information on training. <u>Nursing Management/Administrative Activities:</u> 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: • All of the nursing protocol cards were implemented and all of the nursing staff were trained. The Nurse Managers and the QA Nurse completed the audits according to the nursing monitoring process. • The process for Acute Care Plan audits was revised and implemented in January 2014 to include all care plans into the same sample group since the questions were the same for each type of care plan. All of the other steps remained the same. In addition, the Nurse Managers completed audits of the Care Plan Books to monitor for completion of the Acute Care Plans and to identify issues in process. • Community Living Discharge Planning (CLDP) Guidelines were established for nursing responsibilities in preparation for individuals' move into the community. The RN Case Manager Supervisor was in the process of providing RN Case Managers additional training on the CLDP guidelines. The Monitoring Team did not review these Guidelines. <u>Nursing Monitoring Results for Nursing Protocol Cards and Care Plans:</u> Refer to Provision M.1, Quality Assurance Activities for nursing protocol care and care plan monitoring data. <u>Monitoring Team's Review of Skin Integrity ACPs and Related Documentation:</u> The Monitoring Team independently reviewed a sample of four individuals with recent and/or currently active Skin Integrity ACPs and related documentation for Individuals #286, #639, #331, and #371. Findings included the following: • Four of four (100%) ACPs were initiated upon diagnosis of the pressure wounds. • Three of four (75%) ACPs contained baseline data that succinctly described the condition that led to the necessity for the care plans. • Three of four (75%) ACPs were individualized sufficiently to meet the individuals' health care needs. • Three of four (75%) ACPs contained clinically sound and appropriate immediate and proactive interventions to resolve and/or prevent future occurrence of skin integrity issues, including treatment regimens specific to the individuals' physician orders. • Zero of four (0%) ACPs included relevant nursing protocols, such as Antibiotic	

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		Therapy and Pain Protocols. • Three of four (75%) ACPs made reference to following other disciplines, such as Habilitation/PNMPs and Repositioning Schedules. It was positive to find these references, which indicate that care was being coordinated with other disciplines. • Three of four (75%) ACPs specified the frequency actions/interventions to be performed and the documentation requirements. • Two of four (50%) ACPs were reviewed/revised weekly or more frequent when indicated. • One of one (100%) ACP indicated that the pressure wound was resolved. The other three ACPs remained active. • Three of four (75%) 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. • Two of four (50%) ACPs 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. • Zero of four (0%) Integrated Progress Notes documented that nursing intervention were carried out as stated in the ACPs. Even though the skin integrity data for the past six months showed a decrease in the number and incidence rate of pressure wounds, a review of the ACPs and documentation in the Integrated Progress Notes showed no appreciable improvement in the quality and content from the last compliance review. For Example: o The ACP for Individual #639 was insufficient to meet the needs for wound care to the stage IV left popliteal fossa pressure ulcer. The nursing interventions were limited to, "Give ABTs as ordered (7/1 to &/11), continue treatment as ordered by the wound care nurse. Pain management per Physician orders." This was an active care plan. The Skin Integrity Nurse and RN Case Manager should review the quality of this care plan and revise it sufficiently to meet Individual #639's wound care needs. The Integrated Progress Notes reviewed for the above individuals were only provided by the Skin Integrity Nurse, with an occasional note by the nursing staff. Therefore, it could not be determined if the nursing staff carried out and documented the nursing interventions stated in the care plans. The Nursing Department should ensure the care plans are carried out and documented as stated in the plans. <u>Monitoring Team's Review of Urinary Tract Infection (UTI) ACP and Related Documentation:</u>	

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		The Monitoring Team independently reviewed a sample of five individuals with recent and/or current active Urinary Tract Infections Acute Care Plans and supporting documentation for Individuals #430, #362, #91, #404, and #590. Four of five individuals with recent and/or current active UTIs had ACPs. Individual #362 was diagnosed and treated for a UTI in the hospital that was resolved at the time of discharge; therefore, an ACP was not necessary. Findings included the following: • Four of four (100%) ACPs were initiated within 12 hours of diagnosis of the UTI. • One of four (25%) ACPs had baseline data sufficient to identify how the UTI led to the necessity for care plans. • Three of four (75%) ACPs had goals sufficient to identify the desired outcomes of the UTIs for which the care plans were designed to resolve. • Two of four (50%) ACPs were individualized sufficient to meet the individuals' care for UTIs. Two of four plans were generic and copied directly from the template without any modification that would individualize the plans. • Two of four (50%) ACPs incorporated Nursing Protocols for UTI, Antibiotic Therapy, Pain, and/or other relevant protocols. • Zero of four (0%) ACPs included notification of the Infection Control Preventionist of the UTI. • Two of four (50%) ACPs included the frequency for all nursing interventions that were to be completed, by whom, and where documented. • Two of four (50%) ACPs showed they were review/revised weekly or when interventions/treatments for UTIs were changed. • Two of three (67%) ACPs contained documentation when UTIs were resolved. One of the four ACPs was still in process and was not due to include documentation that the UTI was resolved. • Four of four (100%) ACPs s contained signatures verifying that the respective Home Managers/Charges and DSPs on all three shifts were trained on the DSP Instruction Sheet. • Four of four (100%) Integrated Progress Notes showed UTI, Antibiotic Therapy, and Pain Nursing Protocols were followed at least ever shift. The Monitoring Team's review of the above four UTI ACPs showed no overall appreciable improvement from the last compliance review. However, a review of the documentation in the Integrated Progress Notes showed significant improvement. The Integrated Progress Notes consistently, with rare exception, followed the Nursing Protocols for UTIs, Antibiotic Therapy, and Pain through to resolution. However, when UTIs were resolved typically the notes stated the antibiotic therapy was completed and the problem was resolved, but did not include nursing assessments that demonstrated individuals' health status at the time the UTI was resolved.	

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		Monitoring Team's Review of Reportable Infectious/Communicable Disease ACPs: The Monitoring Team independently reviewed a sample of four individuals with recent and/or current active Reportable Infectious/Communicable Disease Acute Care Plans and related documentation for Individuals #298, #279 (two ACPs), #218, and #517. Of the four individuals with recent and/or current active Reportable Infectious/Communicable Disease, three ACPs were developed and implemented for these infections. Individual #279 was diagnosed and treated for Legionella on 5/21/14 and Clostridium difficile on 6/2/14, but only Clostridium difficile had an ACP developed and implemented. Individual #517 was diagnosed and treated for Trichinella, but did not have an ACP developed and implemented nor were Integrated Progress Notes related to this infection provided to review. Therefore, only three ACPs and related documentation were reviewed. Findings included the following: • Two of three (67%) ACPs were initiated within 12 hours of the diagnosis of the Reportable Infectious/Communicable Disease. • One of three (33%) ACPs had baseline data sufficient to identify how the Reportable Infectious/Communicable Disease led to the necessity for care plans. • One of three (33%) ACPs had goals sufficient to identify the desired outcomes of the Reportable Infectious/Communicable Disease for which the care plans were designed to resolve. • One of three (33%) ACPs contained relevant interventions sufficient to meet the individuals' care for reportable infectious/communicable diseases. • One of three (33%) ACPs incorporated relevant Nursing Protocols for Antibiotic Therapy, Pain, Skin Integrity, and other relevant protocols. • Zero of three (0%) ACPs included the frequency for **all** of the nursing interventions that were to be completed, by whom, and where documented. • One of two (50%) ACPs showed they were reviewed/revised weekly or when interventions/treatments for infections were changed. One ACP was resolved within the week of implementation. • Three of three (100%) ACPs contained documentation when they were resolved. • One of three (33%) ACPs contained signatures verifying that the respective Home Managers/Charges and DSPs on **all** three shifts were trained on the Direct Support Professional Instruction Sheets. • Three of three (100%) Integrated Progress Notes showed, Antibiotic Therapy, and Pain Nursing Protocols were followed at least every shift. • Two of three (67%) Integrated Progress Notes included a resolution note. • Four of four (100%) individuals' records reviewed contained Infection Control Notes completed as required for all reportable infectious/communicable diseases. The Monitoring Team's review of the above three ACPs for reportable	

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		infectious/communicable diseases showed no overall appreciable improvement from the last compliance review. However, one ACP was found particularly sufficient and one ACP was found particularly insufficient. Two individuals who should have had ACPs developed and implemented did not have ACPs completed. For example: • Individual #218's Clostridium difficile ACP on 4/9/14 was found to be exemplary, with the exception for including the frequency of assessing and/or monitoring all nursing interventions listed in the plan. This plan could be used an example for training nursing staff on developing ACPs for Clostridium difficile. • Individual #298's Abscess of the Right Thigh Related to MRSA ACP on 7/5/14 found that the nursing interventions listed were insufficient to meet the need for care related to the infection. The nursing interventions were limited to, "Administer antibiotics as ordered (7/14-7/24). Apply treatment to right thigh as ordered. Administer PRN Pain meds as needed." The ACP did not include the how frequently the abscess was to be assessed, monitored, and documented or other infection control preventative measures. The abscess was marked on ACP as resolved on 7/22/14 but there was no resolution note in the IPN. The nursing staff continued to assess and monitor the abscess. The date resolved on the ACP should not be marked as resolved until it is documented as resolved in the Integrated Progress Notes. • Individual #279 was diagnosed and treated on 5/21/14 for Legionella. It was of concern that an ACP was not developed and implemented for this reportable infectious/communicable disease. There was documentation that the Infection Control Preventionist completed the required Infection Control Note. The note documented that the Infection Control Preventionist gave an in-service to member of the Integrated Morning Meeting Report regarding Legionella. In addition, the Infection Control Preventionist completed a Surveillance Report regarding Legionella that detailed daily corrective actions taken. However, this did not negate the need for a Legionella ACP. Integrated Progress Notes were not provided as requested for offsite review for this infection. Therefore, it could not be determined whether relevant nursing protocols were followed. • Individual #517 was diagnosed and treated for Trichinella but did not have an ACP developed and implemented nor were Integrated Progress Notes provided as requested for offsite review related to this infection. Therefore, it could not be determined whether relevant nursing protocols were followed. As was found in previous compliance reviews, the Acute Care Plans showed no appreciable improvement in the development and implementation of care plans that were sufficient 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 showed that individuals' assessments and documentation of care were consistently, with rare exception, completed according	

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		to related protocols for specific health conditions. Individuals with temporary acute changes in health conditions did not consistently have Acute Care Plans developed and implemented. However, the "Nurse Watch" was initiated for the temporary acute changes in health conditions that including following relevant nursing protocol cards, with rare exception. There appeared to be a lack of understanding when to initiate Acute Care Plans verses the "Nurse Watch." The Nursing Department should clarify this issue with the nursing staff. In order to meeting substantial compliance the Nursing Department should continue to ensure that the Guidelines for Care Plan Development, December 2013 are followed. <u>Monitoring Team's Review of Seizure Records and Related Documentation:</u> The Monitoring Team independently reviewed a sample of five individuals with seizure activity January 2014 through July 2014 and supporting documentation for Individuals #411, #81, #126, #772, and #382. Findings included the following: • For the five individuals a total of 184 Seizure Records were reviewed for completeness. Of these records, none of the seizure episodes lasted longer than two minutes. Therefore, none of the individuals required the administration of Diastat to abort the seizure activity. • Of the 184 Seizures Records reviewed nine (4.8%) did not contain the required nursing assessments. This showed significant improvement in completing the Seizure Records according to the Seizure Management Policy and protocol. <u>Monitoring Team's Review of Comprehensive Nursing Review for and Community Living Discharge Planning:</u> The Monitoring Team independently reviewed four Comprehensive Nursing Reviews for Individuals #376, #622, #698, and #332. Findings included the following: • Four of four (100%) Nursing Services Comprehensive Nursing Reviews were completed within 45 days of discharge. • Four of four (100%) individuals had training sheets for community placement that listed the training provided by the Facility RN Case Manager to the receiving agency nurse. The training sheets provided brief summaries of individuals' health status in relation to each identified high and/or medium risk condition with some limited instruction of what the agency staff should do. In addition to the Comprehensive Nursing Review, the Monitoring Team requested copies of the individuals' complete Community Living Discharge Packets for the review, but they were not provided as for previous reviews. The RN Case Manager Supervisor reported that CLDP Guidelines had been developed, implemented, and the RN Case Manager trained on nursing responsibilities related to community placement. However,	

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		the Monitoring Team was not provided with the guidelines. Therefore, based on the limited information reviewed in the Comprehensive Nursing Reviews and training sheets and a lack of the guideline defining nursing responsibilities for community placement, it was not possible to determine the adequacy of the information provided to the agency regarding individuals continued clinical needs. The Facility's Self-Assessment stated they were not in substantial compliance with this Provision and the Monitoring Team concurs. New Guidelines for Care Plan Development were implemented in December 2013. The Nursing Department needs to ensure that the nursing staff follows the guidelines in order to continue to move forward toward compliance with this Provision. In addition, the RN Case Managers should follow the CLDP guidelines regarding nursing responsibilities to ensure that the community agencies are provided sufficient information regarding individuals' clinical needs for continued supports and services. Refer to Section T for additional information regarding community placement. Refer to Provision M.5 and Section I, Provision I.1 and I.2 for additional information regarding the risk rating process and Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs).	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	<u>Monitoring Team's Findings:</u> The Monitoring Team verified 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, Nurse Educators, and Compliance Nurse. Related Self-Assessment data were updated while onsite. The Monitoring Team's compliance review findings for this Provision were consistent with the Facility's Self-Assessment of activities engaged in to conduct and report the results of the self-assessment. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.4 and the Monitoring Team concurs with their findings. <u>Revised Guidelines:</u> DADS SSLC Nursing Competency Based Training Curriculum Guidelines, Revised: March 2014 <u>Annual Nursing Competency Training, New Nurse Education Orientation, and Supplemental Training Reports:</u> • The Nurse Educators continued to maintain an excellent, comprehensive, and up to date Nursing Standardized Procedures-Protocols-Guidelines Spreadsheet that indicated the percentage of the nurses that had completed the required training, as well as nurses who had not completed the training, with projected dates for	Substantial Compliance

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completion. The database included the overall percentages of nurses trained through 7/18/14.

- 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 of the 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. All relevant Nursing Protocol Cards were incorporated into related annual competencies training as well as with NEO training.
- The Nurse Educators maintained monthly Nursing Education Summary Reports that described in detail all education/training activities performed.
- The chart below reflects the status of Annual Nursing Competency Training completed through to 7/18/14. The chart below shows the percentage of nurses that had completed annual nursing competency-based training requirements, as well as a projected completion dates for nurses who had not yet completed the required training.

Competencies/Training Required by SSLC Nursing Services	RN Core #	Percent Trained	LVN Core #	Percent Trained	Date Trained	Projected Completion Date
RN Acute Care Planning	86	91%	N/A	N/A	1/6-1/8/14	8/30/14
MOSES/DISCUS RN Case Managers	27	100%	N/A	N/A	1/27-1/31/14	Completed
Emergency Equipment Skills Checklist	102	97%	77	97%	2/2014	8/30/14
Skin Management and Wound Care	102	92%	77	96%	3/2014	8/30/14
G-Tube Insertion/Stoma Care Enteral Medication Administration	102	92%	77	92%	4/2014	8/30/14
Nursing Documentation Guidelines Emergency/Hospital Transfer	102	95%	77	96%	5/2014	8/30/14
Hospital Transfer Documentation Progress Note/Transfer Form/Protocol	102	65%	77	62%	6/2014	8/30/14
Adverse Drug Reaction	102	100%	77	100%	12/2013	Ongoing

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			and Medication Variance						with NEO
			RN Physical Assessment Class/Check-off	102	100%	N/A	N/A	Completed with incumbent RNs	Ongoing with NEO for RNs
			MAN0100 Combined Medication Administration for Individuals with Intellectual Disabilities.	102	100%	77	100%	Completed with incumbent nurses	Ongoing monthly with NEO
			Documentation	102	98%	77	100%	Completed with incumbent nurses	Ongoing monthly with NEO
			Additional Trainings	RN Core #	Percent Trained	LVN Core #	Percent Trained	Date Trained	Projected Completion Date
			Status Epilepticus/Oxygen Administration Guidelines	102	98%	77	100%	1/20/14	Ongoing with NEO
			Documentation on Hospitalizations/Urgent Care/Emergency Room Visits	102	93%	77	92%	1/13/14	Ongoing with NEO
			Escherichia-Coli and Infection Control (East Field, Pine Ridge and Timber Hill)	14	100%	18	100%	2/7/14	Completed
			Updated Guidelines for Control of Substance Patch Disposal	100	100%	76	100%	3/1/14	Completed – Ongoing with NEO
			Orders that Effect 10-6 shift (Cedar Falls/Houston Park)	15	100%	23	100%	3/22/14	Completed
			Drug Storage Internal and External Medications W-377	100	100%	76	100%	3/27/14	Completed – Ongoing with NEO
			Plan of Correction: W-149, W-331, W-140-B4	102	98%	77	100%	3/27/14	Completed – Ongoing with NEO
			Review of IHCP Action Steps, W-322 (RN Case Managers)	27	100%	N/A	N/A	4/30/14	Ongoing with NEO

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Writing Complete Orders/Pharmacy Audits (East Field)	14	100%	18	100%	5/19/14	Completed
MOSBY CHAPTERS - RNs	RN Core #	Percent Trained	N/A	N/A	Date Trained	Projected Completion Date
Chapter 17 Abdomen	102	98%	N/A	N/A	9/2012	Ongoing with NEO
Chapter 13 Chest and Lungs	102	98%	N/A	N/A	10/2012	Ongoing with NEO
Chapter 21 Musculoskeletal	97	100%	N/A	N/A	1/2013	Ongoing Rotates quarterly with new RNs
Chapter 22 Neurological Assessment	97	100%	N/A	N/A	5/2013	Ongoing Rotates quarterly with new RNs
Chapter 14 Heart	86	99%	N/A	N/A	7/29/13	Ongoing Rotates quarterly with new RNs
Chapter 10 Head and Neck	88	97%	N/A	N/A	10/2013	Ongoing Rotates quarterly with new RNs
Chapter 12 Ear, Nose and Throat	102	51%	N/A	N/A	12/2013	8/30/14, then quarterly with new RNs

Although some of the percentages for training topics at the present time were reported as less than 90% to 95% completed, training was provided on monthly bases and some topics had not yet been completed. Each training topic that was reported as less than 95% completed had a projected date for completion. Training was also made available for make-up during Nurse Education Orientation.

The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions. The training data showed that nursing staff were trained on all of the 23 Nursing Protocol Cards, which were incorporated into the NEO

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		and the required monthly competency based training. All 23 Nursing Protocol Cards were fully implemented and monitored according to the SSLC Nursing Monitoring Guidelines. Care was relatively consistent with protocols, particularly those most frequently implemented for antibiotic therapy, urinary tract infections, pain, and other conditions, assessment and documentation followed the protocols, and the requirements in various protocols for reporting to the medical practitioner were followed. However, relevant nursing protocols were not included in the Acute Care Plans or Integrated Health Care Plans. Although the Guidelines for Care Plan Development, December 2013, does not require these protocols to be included in the Acute Care Plans or Integrated Health Care Plans, the accompanying Integrated Progress Notes reviewed consistently, with rare exception, included documentation that the protocols were followed. The Nursing Department should consider included relevant protocols in the Acute Care Plans and Integrated Health Care Plans to ensure continuity of care. Furthermore, the review of individuals' care did not reveal any significant inconsistencies with the protocols. The Facility's Self-Assessment stated they were in compliance with this Provision. The Monitoring Team concurs that this Provision was in substantial compliance. As reported above substantial compliance was demonstrated through the Monitoring Team's independent review of the Section M Presentation Book, staff interviews, direct onsite observations of nursing care, and review of documents to verify that the Nursing Department had continued to maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	<u>Monitoring Team Findings:</u> 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 Meeting. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.5 and the Monitoring Team concurs with their findings. <u>New/Revised Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Policies, Procedures, and Processes:</u> There were no new/revised Integrated Risk Rating Form and Integrated Health Care Plan Policies, Procedures, and Processes. <u>Activities Performed to Improve the IRRF and IHCP Process:</u> • The Facility established a workgroup to address participation in the ISP process and to develop a plan to monitor the teams.	Noncompliance

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		• The RN Case Manager Supervisor mentored the RN Case Managers on the ISP process and participation. The RN Case Manager Supervisor was in the process of mentoring RN Case Managers to facilitate discussion to integrate drafts for IRRFs and IHCPS from each discipline into the ISPs and ISPAs. The RN Case Manager Supervisor also mentored the RN Case Managers on clinical indicators and Direct Support Professional Instructions. • The IDT members from each discipline will be trained to develop drafts of IRRFs and IHCPs to incorporate into the official IRRF and IHCP for each individual. • Although training was developed and provided to the incumbent IDT members, plans were to improve the training system to train new and tenured professional staff members serving on IDTs. • Quality and timeliness was monitored to improve the development and implementation IRRFs and IHCPs. The RN Case Manager Supervisor provided feedback to the RN Case Managers as issues were identified. • A formal process to assess quality and timeliness will be implemented and an inter-rater reliability process will be established. <u>Monitoring Team's Independent Review of Individuals' IRRFs and HICPs:</u> The Monitoring Team independently reviewed a sample of recent IRRFs and IHCPs of 12 individuals who were determined to be at high and/or medium risk for certain risk conditions. Individuals included: Individual #279 for constipation/bowel obstruction; Individuals #438 and #181 for skin integrity; Individuals #49, #626, #788, and #630 for weight; Individual #436 for gastro intestinal; Individual #744 for diabetes; Individual #513 for respiratory compromise; Individual #692 for osteoporosis, and Individual #586 for seizure. Findings included the following: • Twelve of 12 (100%) individuals had a comprehensive interdisciplinary assessment completed. • Seven of 12 (58%) individuals' assessments were adequate to support their risk levels. • Seven of 12 (58%) individuals' assessments provided information that helped plan how to address the risks. • Eight of 12 (67%) individuals' had an IHCP developed to address identified risk conditions. Four individuals did not have IHCPs developed for the specific risk conditions reviewed, i.e., Individuals: #438, #49, #744, and #630. • Eight of 12 (67%) individuals' IHCPs were implemented within 14 days of approval or were ongoing plans. • Six of eight (75%) individuals' IHCPs met the clinical needs sufficient to address the specific risk conditions reviewed. • Six of eight (75%) individuals' IHCPs included sufficient interventions to minimize the conditions of risks reviewed.	

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		• Eight of eight (100%) individuals' IHCPs were integrated into the ISP and/or were attached to the ISP. • Six of the eight (75%) individuals' IHCPs showed adequate integration among all appropriate disciplines. • Six of the eight (75%) individuals' IHCPs incorporated appropriate functional and measureable objectives into the ISP to measure the efficacy of the plans. • Five of the eight (63%) individuals' IHCPs identified appropriate clinical indicators to be monitored and the frequency. • Two of eight (25%) individuals' IHCPs' Direct Support Professional Instruction Sheets included signatures verifying that they had been trained on all three shifts. • Zero of eight (0%) individuals' IHCPs included relevant Nursing Protocols to use in the event of a temporary acute change in health conditions. The Monitoring Team identified the following concerns regarding individuals' IRRFs and IHCPs: • Assessment of clinical data for Individual #438 indicated a BRADEN score for skin integrity of 14, which should have represented a medium risk for skin integrity. However, because there was no skin breakdown during the past year and supports were in place, skin integrity was rated as low risk. Because of Individual #438's BRADEN score of 14, coupled with her dependent toileting and use of incontinent briefs, non-ambulatory status, development of contractures, and requiring a positioning schedule, she should have been rated at medium risk for skin integrity. The fact that Individual #438 had no skin breakdown during the past year and had supports in place does not negate the need to be rated at medium risk for skin breakdown. Because of the rating of low risk, Individual #438 did not have a plan for skin integrity. Based on clinical data, she should have been considered at medium risk for skin breakdown and had a proactive skin integrity plan put in place. • Individual #49's assessment of clinical data was insufficient to adequately support the risk determination for weight. Based on the clinical data, Individual #49 was a 40 year old male, who weighed 186.7 pounds which was greater than 10% over his Estimated Desired Weight Range (130-160 pounds). He was diagnosed to be Overweight (BMI: 31, Obese, Class I) with Metabolic Syndrome, Hypertension, Mild Hypertriglyceridemia, and Low High-density Lipoprotein. The IDT determined weight risk to be medium. Based on this clinical data Individual #49 should have been considered at high risk for weight. Individual #49's risk for diabetes was low because he had no indications of diabetes documented. However, based on the above diagnoses, age, and weight, consideration should have been given to rate diabetes at medium because of the potential to develop type II diabetes. There was no family history provided regarding diabetes. There was no Integrated Health Care Plan developed for the medium risk for weight. All medium risk ratings should have	

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		a proactive plan because of the risk that the condition could become unstable and progress to a high risk rating. • Individual #436's IRRF clinical data stated there was a need for follow up for cirrhosis secondary to chronic Hepatitis B that was well compensated, and there was recommended a hepatocellular carcinoma screening with ultrasound of the abdomen, alpha feto-protein level, and liver function tests every six months. Clinical data did not include the fact the individual was a Hepatitis carrier. The IHCP did not include the follow-up test recommended for information regarding management of the Hepatitis B carrier status. Neither were infection control measures/precautions included in the plan to prevent the potential risk of exposing Hepatitis B to others. • Individual #744's assessment of clinical data was insufficient for diabetes type II. The data stated Individual #744 had a diagnosis of diabetes type II, but there was no historical data regarding the onset of diabetes type II or family history included. Current status stated that the supports in place were adequate because she was not showing any sign/symptoms of diabetes. However, the last HbAIC test was in January 2014. Neither was there a recent report of blood sugar finger sticks. Individual #744 was admitted 4/30/14. Therefore, these tests should have been completed prior to the 5/22/14 IRRF to accurately determine diabetic status. There was no IHCP specific for diabetes. • Individual #630's assessment of clinical data was comprehensive. It indicated a weight of 143 pounds, which was greater than 20% over estimated desired weight range of 84-103. Individual was on a 1200 calorie controlled diet. During the last year she had a fluctuation in weight of 23 pounds. Individual #630 was a 64 year old female with diagnoses of metabolic syndrome, anorexia, hyperlipidemia and overweight. She was rated at high risk for weight, but did not have an IHCP developed for weight. • Individual #788 was rated at medium risk for gastrointestinal. Individual #788's assessment of clinical data included diagnoses for chronic gastritis, hiatal hernia, and history of H. Pylori. According to the Individual #778's Active Problem List he also had a diagnosis for Hepatitis B Carrier, which was not included in the assessment of clinical data. The IHCP for gastrointestinal risk did not include infection control measures/precautions to prevent the potential risk of exposure of Hepatitis B to others. The Monitoring Team independently reviewed a sample of six IRRFs and IHCPs for evidence that individuals' requirement for continuous and/or intermittent oxygen was addressed for Individuals #435, #218, #690, #513, #739, and #170. Findings included the following: • Six of six (100%) individuals' IRRF assessments for clinical data for respiratory compromise included sufficient information regarding the need for and the supports	

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		in place for continuous and/or intermittent oxygen. • Six of six (100%) individuals' IHCPs mentioned the use of oxygen, but zero of six (0%) of provided specific instructions for the parameters for which the oxygen saturation levels should be maintained, the frequency of monitoring, or where the results were to be documented. Because the above individuals had high risk ratings for respiratory compromise the IHCPs should have included specific instructions for parameters for which the oxygen saturations levels should be maintained, the frequency for monitoring, and where to document the assessments results. During the compliance review, the Monitoring Team met with Nursing Administration/Management staff and the Respiratory Therapy Director regarding individuals who had physician's orders for use of personal oxygen tanks, how often they were checked to ensure there was always a sufficient supply of oxygen in the tanks, and how frequently oxygen saturation levels were checked for individuals' who had orders for continuous and/or intermittent oxygen. The staff stated that the issue of empty oxygen tanks was identified during the 3/28/13 regulatory survey and that corrective action had been taken. For individuals' with personal oxygen tanks an oxygen checklists had been added to each individuals' Nursing Treatment Sheets located in the Medication Administration Notebooks for the nursing staff to check to determine the remaining amount of oxygen in each individuals' tank every shift and to change out the tanks at 250 PSI. There was documentation provided in the Presentation Book showing that the nursing and direct support professional staffs had been trained on the corrective action plan. The Respiratory Therapy Director provided the Monitoring Team with a list of the 14 individuals who had personal oxygen tanks along with the physician's orders for personal oxygen tanks. Those individual who had orders for continuous and/or intermittent oxygen included Individuals #198, #365, #279, #520, #170, #690, #513, #435, #218, #636, #583, #499, #520, and #739. During the compliance visit, the Monitoring Team, accompanied by the NOO and Unit Nurse Manager, observed Individual #690. The personal oxygen tank was found to have an ample supply of oxygen remaining in the tank. Individual #690's Oxygen Checklist was review in the Medication Administration Record and the oxygen tank was checked each shift for 7/1/14 through 7/22/14. The Charge Nurse was interviewed and asked how frequently her oxygen saturation levels were monitored. The Charge Nurse stated they checked the oxygen saturation levels, but when asked if there were physician orders for the parameters for maintaining oxygen saturation levels and the frequency for monitoring oxygen saturation levels the nurse could not answer. After checking the physicians' orders it was discovered there were no orders. This was further discussed with the NOO and Nurse Manager, who stated oxygen saturation levels were being monitored, but was unable to immediately state how frequently levels were checked or	

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		where the results were documented. However, when they checked the documentation, it was discovered that they were checked and recorded at varying frequencies and the results were recorded on a variety of forms/records and filed in a variety of location by both the nursing and respiratory therapy staffs. At the request of the Monitoring Team, copies of individuals' recorded oxygen saturation levels were provided for review. The Respiratory Therapy Director checked the records of the 14 individuals for physician orders for oxygen and found the individuals did not have physician orders for parameters and frequency to monitor oxygen saturation levels. On 7/23/14 and7/24/14, physician's orders for monitoring oxygen saturation parameters and frequencies were obtained for 10 of the 14 individuals. At the request of the Monitoring Team copies of the physician orders was provided for review. The orders for the remaining four individuals were in process of being obtained. Nursing Administration/Management and the Respiratory Therapy Director will discuss and decide which forms and their location will be used to document the physician orders for monitoring parameters and frequency to ensure continuity of the documentation. <u>Monitoring Team's Attendance at an ISP Meeting:</u> The Monitoring Team attended Individual #280's ISP on 7/22/14. Individual #280 attended the first part of the meeting. Individual #280's mother was on the telephone throughout the meeting and actively participated. The mother was very complimentary of the care Individual #280 was receiving at the Facility and expressed the desire for him to remain at DSSLC because of numerous unsuccessful community placements. All relevant disciplines attended the ISP meeting. The active record was present at the meeting, but most of the disciplines referenced and spoke from copies of their clinical documents and notes. The Facilitator was organized, conducted the meeting efficiently, and kept the team focused. Much discussion centered on behavior issues. All of the required ISP issues were covered. The RN Case Manager led the IRRF and IHCP part of the meeting. There was good participation by the disciplines. The Monitoring Team was concerned over the risk rating for aspiration, which was determined at low risk. However, Individual #280 was rated at medium for choking based on the risk of choking because of rapid eating and taking large bites of food, the required chopped texture diet, need for supervision while eating, and special dining instructions to prompt to take small bites and to eat at a lower speed. Individual #280 was rated at medium risk for respiratory compromise because of severe allergies that required treatment with a variety of medications. The individual was seen by the pulmonologist on 7/21/14, but the report was pending. The individual was rated at low risk for aspiration. Individual #280, in spite of the choking risk, had not had a modified barium swallow test to rule in or out risk for dysphagia. The team planned to get a modified barium swallow test, but it had not been scheduled. Since the ISP meeting was	

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		scheduled well in advance of the meeting, it would seem that disciplines responsible for scheduling the Pulmonologist consultation should have scheduled the visit well in advance to have been seen and the report back prior to the ISP meeting so the information could be used in determining the risk rating for respiratory compromise. In addition, since Individual #280 was at medium risk for choking and plans were to schedule a modified barium swallow test, it would seem that the test should have been ordered in advance for the test and the results completed to be available to assist in determining the risk rating for aspiration. All needed diagnostic/consults should be identified during the Pre-ISP meeting should they can be completed before the final ISP meeting. This would assist in ensuring the accuracy of the clinical data and prevent delays identifying risk ratings and prevent additional ISPA meetings. 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. If compliance is to be achieved regarding the IRRF and IHCP processes, the Facility needs to ensure consistency across all IDTs, as well as across disciplines. 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 functional and measurable objectives to measure the efficacy of the plan are considered, as well as including all relevant clinical indicators to be measured for risk ratings. 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 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	<u>Monitoring Team's Findings:</u> The Monitoring Team verified 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 Medication Administration Observations by the Monitoring Team. Relevant Self-Assessment data were updated during the onsite compliance visit. The Monitoring Team's compliance review findings for this Provision were consistent with the Facility's Self-Assessment of activities engaged in to conduct and report the results of the self-assessment. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the Monitoring Team concurs with their findings. <u>New and/or Revised Medication Administration Policies and Procedures:</u> • DSSLC Procedure: Medication Administration Guidelines – Addendum A for DSSLC,	Substantial Compliance

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	accepted professional standards of care with regard to this provision in a separate monitoring plan.	Date: December 2013 • Refer to Section N for Pharmacy related policies and procedures <u>Medication Administration Training:</u> • Refer to Provision M.4 for training reports regarding medication administration practices. <u>Pre- Medication Variance Committee, Medication Variance Committee, and Pharmacy and Therapeutic Committee findings:</u> • 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. • As found in previous compliance reviews, the Monitoring Team's independent review of the monthly Pre-Medication Variance Committee meeting minutes, January 2014 through June 2014, found: o The Nursing Pre-Medication Variance Committee Meeting Minutes showed that Nursing Administration continued to conduct monthly Nursing Pre-medication Committee Meetings. 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 they were local or systemic, as well as corrective actions/follow-up taken by the respective Nurse Managers. The unit/Infirmary Nursing Pre-medication Medication Variance Reports were submitted and reviewed at the monthly Pre-Medication Variance Committee meetings for further review and disposition. o Pre-Medication Variance Committee Meeting Minutes showed that 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 they were local or systemic, as well as corrective actions/follow-up taken by the respective discipline. The Monitoring Team's independent review of	

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		the Nursing Pre-Medication Variance Committee and the Pre-Medication Variance Committee minutes found that the local corrective actions appeared clinically sound and appropriate specific for medication variances reported. There were no systemic medication variances reported that required CAPs. The Pre-Medication Committee Reports were present for reviewed/discussion at the monthly Medication Variance Committee meeting for further review and disposition. • The Medication Variance Committee was comprised of the Pharmacy Director (Chair), Medical Director, Facility Director CNE, NOO, Director of Quality Assurance, Health Service Compliance Coordinator, Center Director, and Residential Services Director. The committee consistently met monthly. The meetings followed an established agenda and were conducted efficiently and effectively. 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. Pertinent information regarding medication variances was reviewed/discussed, and corrective action was taken by the respective clinical disciplines when necessary. The Medication Variance Committee minutes showed they reviewed/discussed the medication variance data, issues leading to the medication variances, and the corrective action taken, as well as other related medication administration practices. 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 the Monitoring Team's attendance at the Medication Variance Committee meeting on 7/21/14; and at the Pharmacy and Therapeutics Committee meeting on 7/22/14. Refer to Section N for additional information regarding medication administration practices. <u>Medication Variance Reports:</u> 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,	

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contributing factors, and medications associated with the variance. The database also included Inspection and Storage data. The data were represented by bar graphs and tabular charts; including the number of variances represented, with a color coded legend explaining the graphs. This data provided the Facility with detailed medication variance information from which to make decisions for corrective action to reduce the incidents of variances. The Monitoring Team was provided with medication variance data January 2014 through June 2014 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 January 2014 through June 2014:

Severity Index	A	B	C	D	E	F	G	H	I	Monthly Total
January	121	3	51	3	0	0	0	0	0	178
February	161	6	49	1	0	0	0	0	0	217
March	111	7	50	0	0	0	0	0	0	168
April	124	5	27	3	0	0	0	0	0	159
May	145	7	24	2	0	0	0	0	0	178
June	206	4	25	2	0	0	0	0	0	237
Total	868	32	226	11	0	0	0	0	0	1137

The charts below shows the total number of medication variances by department, reported January 2014 through June 2014:

Month	Medical	Nursing	Pharmacy	Dental	Other	Total
January	31	58	89	0	0	178
February	32	58	126	0	1	217
March	26	57	83	2	0	168
April	49	34	75	1	0	159
May	67	32	79	0	0	178
June	37	26	174	0	0	237
Total	242	265	626	3	1	1137

The above data overall showed no appreciable increase in the number of medication variances from the last compliance review, which was reported as a total of 1090 compared to this compliance review with a total of 1137 medication variances reported. This showed an overall increase of 47 medication variances or 4% increase. Notably there was a considerable decrease of 265 nursing medication variances reported in this review compared to the previous review where 441 nursing medication variances were reported. This showed a decrease of 176 nursing medication variances or 40% decrease.

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		It was evident since the last compliance review that 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. It would appear that the previous and ongoing corrective actions were demonstrating effectiveness in preventing and/or reducing the incidences of medication variances. <u>Monitoring Team's Review of Ten Most Recently completed Medication Variance Reports:</u> The Monitoring Team's review of the Facility's ten most recently completed Medication Variance Reports for Individuals #752, #352, #534, #78, #336, #402, #404, #689, #113, and #92, 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 they were presented to the Medication Variance Committee for further review and disposition. <u>Facility Medication Administration Observations:</u> 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 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 Therapeutics Committee for further review and disposition. The Medication Administration Observation data below shows the overall units/Infirmary monthly percentage of compliance with the Medication Administration Observation Tools and level of agreement between the Nurse Managers and the QA Nurse, June 2014 through June 2014: | Month | January | February | March | April | May | June |	

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			2014			
Percentage of Compliance	98%	97%	98%	98%	98%	98%
Inter-rater reliability	96%	96%	100%	100%	98%	N/A

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

Physical and Nutritional Management Team (PNMT) Nurse Medication Administration Observations:

The PNMT Nurse continued to conduct periodic medication administration observations. The Monitoring Team was provided a sample of four completed Universal Monitoring Forms for PNM Compliance and Effectiveness for Individuals #760, #463, #351, and #690. For compliance a score of 80% and above must be achieved. Findings included:

- Individual #760 was observed on 4/4/14 with a compliance score of 90%.
- Individual #463 was observed on 3/4/14 with a compliance score of 90%.
- Individual #351 was observed on 2/12/14 with a compliance score of 80%
- Individual #690 was observed on 1/20/14 with a compliance score of 90%.

Monitoring Team's Independent Medication Administration Observations:

The Monitoring Team conducted medication observations and medication room surveys in Houston Park for 513B apartment at the morning medication pass on 7/22/14 and Garden Ridge 524 A and B apartments at the evening medication pass on 7/23/14, 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 to the medications they were receiving and the purpose of the medications. There was one minor instance with the first individual administered medications where the Houston Park nurse was reminded by the NOO to ensure individuals were told the names and purpose of medication. Thereafter, the nurse consistently informed individuals the names and purpose of their medications. This initial omission was likely due to the nurse's reviewing the individual's Medication Administration Record with the Monitoring Team.
- 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, including the use of adaptive equipment when indicated. All individuals' observed had a current PNMP present in their Medication Administration Records (MARs).

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		• 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 enteral medication 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. Privacy was consistently provided for each individual. • Informal Self-Administration of Medications (SAMs) training was conducted for individuals who had programs. Formal training data reporting for SAMs was not scheduled during the time medication administration observations were conducted. • It was positive to find since the last review medication rooms had been created in Houston Park 513 A and B apartments. Garden Ridge continued to have medication rooms as was found at previous compliance reviews. <u>Issues identified during the medication administration observations:</u> • Individual #361: While reviewing Individual #361's Medication Administration Record, it documented no known allergies (NKA). However, "Lactose" was listed after the NKA. It should have stated allergies/intolerance to Lactose. Individual #361 takes medications orally and receives liquid Colace, which had a bitter taste that caused resistance/refusal to take when mixed in plain water. The Nurse Manager followed up on these issues and provided the Monitoring Team with documentation of the outcome. The Nurse Manager contacted the provider who ordered a radioallergosorbent (RAST) test to confirm or deny Lactose Intolerance on 7/23/14. The Pharmacy was contacted regarding the bitter taste of liquid Colace mixed in plain water and asked if this medication could be mixed with something to make the taste more palatable or if it came in different flavors. The Primary Care Provider (PCP) was also notified of this concern. • Individual #586: Individual #586 was a 16 year old male who was admitted 2/12/14. During the observation Individual #586 was observed to have issues of concern identified: Excessive drooling/salivation, difficulty maintaining correct positioning in his wheelchair/harness, and difficultly with the instillation of medication and enteral formula by gravity flow through a small lumen G-tube. When the Monitoring Team asked if the provider had evaluated the excessive drooling, the nursing staff stated they did not believe he had been evaluated. Although the staff provided assistance with positioning during the enteral administration of medication it was not possible for the individual to self-correct and/or maintain correct positioning independently. The PNMP instructions for positioning for medication administration stated, "Sit in upright wheelchair - OK to tilt back OR in bed with HOBE at 25°." There were no instructions for staff to prompt him to set upright or	

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		for staff to assist with correct positioning. The Nurse Manager followed up on these issues with the PNMT and PCP and provided the Monitoring Team with documentation of the outcome. On 7/23/14 the PCP prescribed Robinul one mg via G-tube three times a day for excessive salivation. Individual #586's mother was notified of the treatment for excessive drooling/salivation and was agreeable with the treatment. The PCP ordered the G-tube changed to a 20 French tube to facilitate instillation of medications/flushes/feedings because the G-tube he had was a pediatric size with a small lumen. The Habilitation Department had worked on the individual's harness and wheelchair to help with positioning. The Habilitation Director stated the IDT would meet to discuss his positioning needs. It was of concern to the Monitoring Team that the difficulty with the instillation of medications/flushes/feeding through the G-tube was not identified earlier because this problem did not appear to have suddenly occurred. The nursing staff should promptly report any identified difficulty with enteral instillation with the G-tube to the PCP and PNMT for evaluation. • Individual #283: During the observation Individual #283's head tilted to the right and came off the head rest. Individual #283 could reposition self when verbally prompted, but the PNMT did not include instructions for staff to verbally prompt him to correct his position. When the nurse was checking his blood pressure the Monitoring Team's review of the order for Amlopidine found it did not include parameters for systolic and diastolic blood pressure and heart rate ranges. The Nurse Manager followed up on these issues with the PNMT and PCP and provided the Monitoring Team with documentation of the outcome. On 7/2/14 the PCP was notified and ordered parameters for systolic and diastolic blood pressure and heart rate ranges. The Habilitation Director was contacted regarding adding a prompt to the PNMP to for staff to verbally prompt Individual #283 to self-correct position when provided oral intake. The Habilitation Director agreed that this was a good idea and that she would request the IDT to meet to discuss/determine adding the verbal prompt to self-correct position during oral intake. • It was positive to find that all blood pressure medications included the parameters for blood pressure ranges and heart rates. The nurses consistently assessed blood pressures and heart rates prior to administering the medication. However, nonprofessional grade wrist instruments were used. Several of these instruments either did not work or gave inaccurate readings. Then, the nurses used the standard blood pressure cuff and stethoscope to assess blood pressures and heart rates. The nurses stated the wrist instruments were used because they were more comfortable for individuals. Although individuals' comfort must be respected, it is essential that blood pressure and heart rate assessments are accurate in order to regulate the correct dose of blood pressure medications. The Facility should consider procuring professional grade instruments to ensure that assessments of blood pressures and	

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		heart rates are accurate. • A review of the July 2014 MARs for individuals in Garden Ridge found several medications were neither initialed nor circled. The Nurse Manager should review the July 2014 MAR for medications that were neither initialed nor circled and investigate for medication variances. • A review of the units/homes and Infirmary Universal Signature Sheets found that a few nursing signatures were missing corresponding initials. The Nurse Managers should review all Universal Signature Sheets to ensure that all nurses who provide medication administration have signatures and corresponding initials. • A review of all units' Control Drug Sheets and Equipment Checklists for the past two months found as required, with rare exception on the 10-6 shifts where the unit/home may not require an assigned nurse but was supported by the campus nurses as needed, they were completed on each shift and initialed with by both the on-coming and off-going shift nurses. This continued to show improvement as was found in previous compliance reviews. 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 track, analyze and provide local and systemic corrective action plans. Therefore, this Provision was found in substantial compliance. Although substantial compliance was found at this compliance review, 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. Further, the positive medication administration practices, medication variances procedures, and processes demonstrated by this Facility were exemplary to their peers and should be recognized as such.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self Assessment, 7/3/2014 2. DSSLC Action Plan (undated) 3. DSSLC Presentation Book for Section N 4. DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 04.01.04, revised 2/26/2014 5. Medication orders for Individuals #187, #129, #499, #602, #631, #656, #507, #581, #654, #380, #289, and #37 6. Single patient drug intervention reports (SPDI) for Individuals #656 and #37 7. Quarterly drug regimen reviews (QDRR) for Individuals #701, #90, #660, #19, #79, #180, #351, #705, #474, and #170 8. QDRR schedule for past six months, and pending six months 9. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date 10. Alpha list of individuals who were prescribed a neuroleptic and have diabetes 11. Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension 12. Alpha list of individuals who were prescribed a benzodiazepine 13. Alpha list of all individuals with diagnosis of osteoporosis 14. Alpha list of all individuals with diagnosis of seizure disorder 15. Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties 16. Data, graphs, and data analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties 17. Alpha list of individuals who are prescribed anticholinergic drugs 18. For the first five individuals on the list of individuals prescribed anticholinergic drugs (Individuals #302, #704, #739, #633, and #670) a. Most recent two QDRRs b. Current medical list c. Most recent medical and psychiatric annual reviews d. Most recent MOSES and DISCUS assessments 19. Most recent two QDRRs for Individuals #399. #4, #459, 456, #703, and #581 20. Most recent psychiatric medication oversight committee (POMC) meeting minutes 21. List of all individuals on polypharmacy 22. For the first five individuals on the list of polypharmacy (individuals #28, #605, #386, #7, and #165) a. Most recent two QDRRs b. Most recent psychiatric assessment c. Current medication list

	d. Most recent ISP, or related document the use of polypharmacy 23. For Individuals #658, #110, #526, #553, #791, #397, #477, #599, #671, and #490 a. Most recent QDRR b. Most recent IRRF c. Current medication list d. Most recent six months laboratory data e. Most recent annual medical assessment f. Most recent psychiatric assessment g. Most recent IRRF, and ISP or addendum to the ISP documenting risk for metabolic syndrome 24. Copy of the Facility's Face-to-Face debriefing report for all stat chemical restraints during this reporting period 25. List of all stat chemical restraint data, data analysis, and summaries for the use of stat chemical restraints during the reporting period 26. Pharmacy and Therapeutics Committee (P&TC) meeting minutes, 3/31/2014 27. Post chemical restraint clinical review form, undated, no identifying information list 28. MOSES and DISCUS assessment reports completed during this reporting period for Individuals #703, #90, #66, #19, #79, 180, 351, #474, #705, #170, #580, #666, #251, #18, #131, #371, #774, #702, #388, and #703 29. Facility's spreadsheet for adverse drug reaction (ADR) tracking database, data, and analysis, dated 1/2014 through 7/2014 30. Pharmacy and Therapeutics Committee (P&TC) meeting minutes, dated 7/22/2014 31. Completed ADR reports, and associated individual progress notes (IPNs) for Individuals #527, #59, #631, #94, #706, #319, #581, #365, and #502 32. Training roster for direct care staff for reporting ADRs 33. Drug utilization evaluation (DUE) schedule, for this reporting period 34. Copy of DUE developed and implemented for Diastat 35. Copy of all scheduled DUEs that were developed for this reporting period. 36. Medication variance data, and trends analysis for all variances that occurred during this review period 37. Medication variance committee minutes for May 2014, June 2014, and July 2104 38. Medication variance report forms Individuals #376, #626, #28, #520, #492, #779, #88, #499, #131, and #394 **People Interviewed:** 1. Jana Boone, R Ph, Pharmacy Director **Meetings Attended/Observations:** 1. Polypharmacy Committee 2. Pharmacy and Therapeutics Committee (P&TC)
	Facility Self-Assessment: Following its review of the Self-Assessment for Section N, the Monitoring Team noted that: • The Facility did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement.

	• The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did not identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall.. The number or percent of sample size of individuals/records as compared to the overall population was not consistently included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, but only provided overall percentage of compliance. • The Monitoring Team determined that the Facility's monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. This was evident by the lack of consistency among the various sections reviewed for this Provision. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools; however, based on self-assessments for the past three compliance reports, the outcome of the self-assessment appeared consistent. The Facility determined that it was in substantial compliance for Section N.1 through N.8. The Monitoring Team concurs with the Facility's assessment of substantial compliance with Sections N.1, through N.8.
	Summary of Monitor's Assessment: The Facility has made marked improvements in the area of pharmacy services. Significant improvements were noted with more relevant clinical information being provided on the QDRRs, and more comprehensive review of polypharmacy, benzodiazepine usage, anticholinergic usage, and assessment of metabolic syndrome. Furthermore, since March 2014, the Facility had enhanced its reporting of adverse and potential adverse drug reactions on the IRRF assessments. The Monitoring Team remains complimentary of the Facility's medication variance and drug utilization evaluation process. There was documented evidence demonstrating review of new medication orders by the pharmacists for adverse drug reaction, allergies, appropriate indication, and dosage. There were many examples cited of MOSES and DISCUS assessment forms not being fully completed by the medical provider; the Facility will need to address that issue and ensure full completion. The Facility is in substantial compliance with Sections N.1, through N.8. **Section N.1:** Of the 12 new medication orders reviewed, the pharmacist documented review for allergies, indication, dosage, route, and potential interactions in 10 our of 12 examples (83%). Two out of three (67%) new medication orders that included a SPDI for potential drug interactions included evidence that the medical provider followed up on the recommendations by the pharmacists, when necessary. Because the majority of new medication orders reviewed by the Monitoring Team indicating clinical review by the pharmacists, the Facility is in substantial compliance with Section N.1 **Section N.2:** The Monitoring Team noted significant improvement with completion of the QDRRs that include a high level of professional review, and determined that the Facility is in substantial compliance

	with Section N.2. **Section N.3:** The Facility documented an adequate review of polypharmacy, benzodiazepine, anticholinergic and stat chemical restraint usage, and clinically appropriate review of metabolic syndrome, and is in substantial compliance with Section N.3. **Section N.4:** Because the medical provider reviewed and accepted the pharmacist's recommendations, the Facility remains in substantial compliance with Section N.4. Sect**ion N.5:** Per the last compliance report, the Monitoring Team was concerned that the Facility did not ensure more frequent monitoring for tardive dyskinesia (TD) following the change in dose of a neuroleptic. During this compliance period, 80% of the examples reviewed demonstrated more frequent monitoring for TD following a change in neuroleptic dose. The Facility must enhance completion of the evaluation, and physician component of the DISCUS assessments. **Section N.6:** Because the Facility identified, reported, and followed up on adverse drug reactions (ADRs), the Facility meets substantial compliance for its ADR process; however, the Monitoring Team strongly recommends that the Facility enhance follow-up by medical providers, and ensure that the reporting of all ADRs occurs at the time of identifying an ADR. **Section N.7:** Because the Facility conducts clinically relevant DUEs for scheduled and when clinically necessary, the Facility continues substantial compliance with Section N.7. **Section N.8:** The Facility continued to implement and maintain a robust process to track, trend, analyze, and implement corrective action, when necessary, for medication variances. The Facility's database for tracking medication variances is robust, and not only delineates the severity of variances, but identifies the relevant department, and staff member who was responsible for the variance. The medication variance committee consists of leadership from all relevant departments, including nursing, pharmacy, and medical. There was evidence to indicate meaningful action steps to help mitigate medication variances in the future. The Monitoring Team compliments the Facility for developing, implementing and maintaining a robust medication variance process, and determined that the Facility is in substantial compliance with Provision N8.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's	To assess continued compliance with Provision N.1, the Monitoring Team reviewed copies of the first two new medication orders written during each month of this review period, along with associated single patient drug intervention reports (SPDI); pharmacy documentation of a review for allergies, interactions, appropriate indication, and dose; past six months laboratory data; current medication list; EKG for past three years; and most recent ophthalmology consultation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Review of the requested documents for Individuals #187, #129, #499, #602, #631, #656, #507, #581, #654, #380, #289, and #37), indicated the following: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, and indications in 10 out of 12 examples (83%) • The pharmacist reviewed new medication orders for drug interactions in 10 out of 12 examples (83%). Of the three examples that included a potential drug interaction, one of the three examples (Individual #656) did not include evidence of the medical provider's follow-up to the drug SPDI report for drug interaction between acetazolamide and scheduled aspirin., and there was no evidence the pharmacist provided specific recommendations to the medical provider for the potential drug interaction. Conclusion: Of the 12 new medication orders reviewed, the pharmacist documented review for allergies, indication, dosage, route, and potential interactions in 11 our of 12 examples (92%); however, only one out of three (33%) new medication orders that included a SPDI for potential drug interactions, included evidence that the medical provider followed up to the recommendations by the pharmacists. Maintaining substantial compliance will require that the pharmacist ensure documentations of specific recommendations for potential drug-drug interactions, and evidence that the medical provider appropriately addressed the pharmacist's recommendations. Because most of new medication orders reviewed by the Monitoring Team indicated clinical review by the pharmacists, the Facility is in substantial compliance with Section N.1	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	To assess that the Facility conducts quarterly drug regimen reviews (QDRRs), that are 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: • QDRR schedule for past six months, and pending six months • List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date • Alpha list of individuals who were prescribed a neuroleptic and have diabetes • Alpha list of individuals who were prescribed a neuroleptic and have diagnosis of hypertension • Alpha list of individuals who were prescribed a benzodiazepine • Alpha list of all individuals with diagnosis of osteoporosis • Alpha list of all individuals with diagnosis of seizure disorder • The Monitoring Team selected the following examples from the alpha lists-- Individuals 701, #90, #660, #19, #79, #180, #351, #705, #474, and #170:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		○ Most recent two QDRRs ○ Past six months MOSES and DISCUS assessments ○ Most recent 12 months of lab results ○ Most recent two EKG reports ○ Most recent annual physician summary ○ Most recent psychiatric assessment ○ Most recent IRRF ○ Current medication list ○ 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 The following is a summary of the Monitoring Team review of the examples provided for Individuals: • Of the ten examples, ten out of ten (100%) were completed within 14 days of the annual ISP meeting. • The pharmacist assessed Laboratory and other diagnostics, such as EKGs and DEXA scans, in ten out of ten examples (100%). • Metabolic syndrome was appropriately assessed in ten out of the ten examples (100%) that required a review for metabolic syndrome. • The QDRR indicated review by the medical provider in ten out of ten examples (100%). • The QDRR indicated review by the psychiatrist in eight out of the eight examples (100%) of the QDRRs that required review by the psychiatrist. • MOSES and DISCUS assessments were reviewed by the pharmacist in ten out of ten examples (100%); however, MOSES and DISCUS were fully completed by the medical provider in seven out of ten examples (70%). The DISCUS assessments for Individuals #351 and #19 were not completed by the physician, and the MOSES for Individual #703 indicated a completion date of 5/12/2013, but was signed by the medical provider on 5/12/2014. • The QDRR clearly delineated effectiveness of all drugs prescribed in ten out of ten examples (100%). • Of the ten examples, there were ten instances of polypharmacy, and in ten out of ten examples (100%), the pharmacist addressed polypharmacy. • For the four individuals treated with benzodiazepines, four out of four (100%) examples indicated a specific assessment for the use of benzodiazepine by the pharmacist that included a statement indicating the clinical appropriateness. • The Monitoring Team noted in ten out of ten examples (100%), the pharmacist indicated a review of all medications, which included a statement specific for	

#	Provision	Assessment of Status	Compliance
		clinical appropriateness and side effects. It should be noted that as of March 2014 the Facility implemented a process that included the indication of possible side effects to medications within the context of the IRRF process, and the Monitoring Team identified the inclusion of medication side effects on the four IRRF assessments that were dated after March 2014. Summary: The Monitoring Team noted significant improvement with completion of the QDRRs that include a high level of professional review, and determined that the Facility is in substantial compliance with Section N.2.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	To assess the Pharmacy's ability to monitor and address stat medication use, metabolic syndrome, use of benzodiazepines, polypharmacy, and the use of anticholinergic medications, the Monitoring Team discussed the provision with the pharmacy director, reviewed the presentation book, and requested the following clinical information: • List of all individuals who were prescribed an antipsychotic medication and had diabetes and/or hypertension, and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk of metabolic syndrome • List of all individuals who were prescribed an anticholinergic and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk of anticholinergic medications • List of all individuals who were prescribed benzodiazepines and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk associated with the use of benzodiazepines • List of all individuals who were prescribed psychotropic polypharmacy, and for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT, specific to the risk of psychotropic polypharmacy • List of all individuals who were prescribed a stat psychotropic medication for a behavioral indication and, for the first ten individuals on the list, a copy of the most recent two QDRRs, annual medical assessment, annual psychiatric	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		assessment, last six months labs, current medication list, and copy of all ISP and related documents indicating discussion by the IDT specific to the use of the stat psychotropic medication, including a copy of the Face-to-Face form • Copies of all data, data analysis, reports, committee meeting minutes, action plans and follow-up on action plans, used as part of a systems review for the system issues secondary to the use of benzodiazepines, anticholinergics, stat chemical restraint, polypharmacy, and metabolic syndrome <u>Review of Anticholinergic Usage</u> To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents: • Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties • Data, graphs, and data analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties • Alpha list of individuals who are prescribed anticholinergic drugs • For the first five individuals on the list of individuals prescribed anticholinergic drugs (Individuals #302, #704, #739, #633, and #670) o Most recent two QDRRs o Current medical list o Most recent medical, and psychiatric annual reviews o Most recent MOSES and DISCUS assessments The following is a summary of the pharmacy's clinical review of anticholinergic medications during the QDRR process for Individuals #302, #704, #739, #633, and #670: • In five out of five examples (100%) the QDRR documented the indication for the use of all anticholinergics prescribed. • In five out of five cases (100%), the QDRR documented risks associated with the use of anticholinergics. • In five out of five examples (100%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics. • The Pharmacist documented a comprehensive review of the use of medications usage associated with anticholinergic properties in five out of five examples (100%). <u>Assessment of Benzodiazepine usage</u> The Facility tracked the use of benzodiazepines for all uses, including neurological and psychiatric indications, and conducted a comprehensive clinical review of benzodiazepine usage during the QDRR process.	

#	Provision	Assessment of Status	Compliance
		Based on review of the most recent QDRR, the Monitoring Team made the following determination for Individuals #399. #4, #459, 456, and #703: • In five out of five cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine. • In four out of five cases (80%), the QDRR documented risks associated with the use of the benzodiazepine. • In four out of five examples (80%), 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 psychiatrists recommendations, the efficacy of pharmacological treatment. • In five out of five examples (100%), the QDRR documented recommendations for continued use. • There were two examples of the pharmacist's enhanced documentation of potential adverse reactions to medications, since this process had been developed in March 2014. Of the two IRRFs that included discussion on benzodiazepine adverse reactions, zero out of two (0%) included specific comments regarding adverse affects secondary to benzodiazepine usage. The Monitoring Team recognized that the pharmacy department had only recently enhanced reporting potential adverse reactions to medications in March 2014. The examples of IRRFs that did not include a statement on adverse reactions were dated prior to March 2014. Furthermore, the Monitoring Team was informed of the pharmacy department's enhanced process, and was shown examples of completed IRRFs since March, that included documentation of potential adverse effects. For four of the five examples reviewed by the Monitoring Team, the Facility ensured a pharmacist's review of the use of benzodiazepines. It would also be advantageous for the Facility to enhance the reporting of potential serious adverse reactions, such as fall risk, and sedation, on the IRRF. <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • Most recent psychiatric medication oversight committee (PMOC) meeting minutes • List of all individuals on polypharmacy • For the first five individuals on the list of polypharmacy (Individuals #28, #605, #386, #7, and #165) o Most recent two QDRRs o Most recent psychiatric assessment	

#	Provision	Assessment of Status	Compliance
		○ Current medication list ○ Most recent ISP, or related document of the use of polypharmacy The following is a summary of the documents reviewed for polypharmacy (Individuals #28, #605, #386, #7, and #165): • In five out of five examples (100%) the QDRR documented the indication for the use of each drug associated with polypharmacy. • In five of five examples (100%), the QDRR documented serious risks for the use the polypharmacy combination. • In five out of five cases (100%), the QDRR documented the use of polypharmacy was clinically justifiable, or provided recommendations for alternative dosage or treatment. • In five out of five cases (100%), the pharmacist documented the efficacy, or lack of efficacy, for the use of polypharmacy. • Of the five examples reviewed, three included IRRF assessments that were completed after the Facility enhanced its IRRF process, to include potential adverse reactions to polypharmacy. Of the three IRRFs reviewed, three out of three (100%) included a comprehensive review, including potential adverse reactions of polypharmacy. As indicated by the five examples reviewed, the Facility ensures clinically appropriate review of polypharmacy. <u>Assessment of Metabolic Syndrome Monitoring:</u> The Monitoring Team selected the first nine 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 #658, #110, #526, #553, #791, #397, #477, #599, and #490) • Most recent QDRR • Most recent IRRF • Current medication list • Most recent six months laboratory data • Most recent annual medical assessment • Most recent psychiatric assessment • Most recent IRRF, and ISP or addendum to the ISP documenting risk for metabolic syndrome The Facility reported a total of 82 individuals being diagnosed with metabolic syndrome, and 48 of the 82 individuals being prescribed an antipsychotic medication.	

#	Provision	Assessment of Status	Compliance
		The following is a summary of the nine examples reviewed for metabolic syndrome, for the seven (Individuals #658, #110, #526, #553, #791, #397, #477, #599, and #490): • Nine of nine QDRRs (100%) indicated specific review for metabolic syndrome on the QDRR report. • Nine out of nine QDRRs (100%) assessed clinically appropriate risk factors to evaluate for metabolic syndrome. • The associated IRRF, or ISP documented a specific risk assessment for metabolic syndrome in eight out of nine examples (89%). Individual #477 was recently admitted to the Facility on 3/11/2014, and the IRRF and ISP was not provided for review. • The Pharmacist commented on the risk versus benefit for either continuing or discontinuing the medication associated with metabolic risk in nine out of nine examples (100%). Summary: The Facility had significantly continued to identify and report on metabolic syndrome, and on risk factors associated with metabolic syndrome. <u>Stat chemical restraint usage:</u> 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: • 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 The Monitoring Team, was provided the following documentation: • List of all stat chemical restraint data, data analysis, summaries, for the use of stat chemical restraints during the reporting period • Pharmacy and Therapeutics Committee (P&TC) meeting minutes, 3/31/2014 • Post chemical restraint clinical review form, undated, no identifying information list. • Most recent QDRR for Individual #671. The Facility reported one stat chemical restraint provided during the reporting period (Individual #671). 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:	

#	Provision	Assessment of Status	Compliance
		• Pharmacist's review: 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. o In one out of one example (100%), the pharmacist documented if side effects occurred following the stat chemical restraint. o In one out of one example (100%), the pharmacist documented if the indication for the stat chemical restraint was appropriate. o In one out of one example (100%), the pharmacist documented if drug and dose used for the stat chemical restraint were clinically appropriate. o In one out of one example (100%), the pharmacist documented if currently prescribed pharmacotherapy could be manifesting in the maladaptive behavior resulting in the need for the stat chemical restraint. • Psychiatrist's review: 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. o In one out of one example (100%), the psychiatrist documented if side effects occurred following the stat chemical restraint. o In one out of one example (100%), the psychiatrist documented if drug and dose used for the stat chemical restraint were clinically appropriate. o In zero 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. o In zero out of one example (0%), 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. o In zero out of one example (0%), 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. The Facility reported a total of one stat chemical restraint usage during this reporting period, and the pharmacist documented a review, indicating the appropriate pharmacological usage of the stat chemical restraint. The documents provided indicated that the psychiatrist documented a review of the stat chemical restraint and indicated appropriate usage, with no observable adverse consequences. The Psychiatrist did not,	

#	Provision	Assessment of Status	Compliance
		however, document a review of the current scheduled psychotropic medication usage, and behavior program. The Facility should encourage the psychiatrist to review scheduled psychotropic medications, and behavior program, to assess if such treatments should be enhanced, to help mitigate the need for future stat chemical restraint. 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, as documented on the 3/31/2014 P&TC meeting minutes. <u>Systems Review of benzodiazepine, polypharmacy, and anticholinergic usage at the Facility</u> 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, which was reflected on an undated copy of P&TC committee meeting minutes, and the March 2014 psychoactive medication review committee meeting minutes. The March PMOC meeting minutes indicated continued decrease in the total number of anticholinergic medications prescribed at the Facility. Between July 2011, and April 2014 intraclass polypharmacy is down from 15 to 12 individuals; and individuals prescribed two anticholinergic medications from the same class was down from 105 to 72 individuals during the same period. Systems review for benzodiazepine usage: As evident by the review of the P&TC meeting minutes for 1/2014 and 6/2014, the Facility conducts specific reviews of the usage of benzodiazepines, twice per year, at the P&TC meeting. The Facility also reviews the overall usage of benzodiazepines at its regularly scheduled QA/QI Council data meetings, as evident by review of the QA/QI Council data meeting minutes for 1/14/2014. At the time of this on-site review the Monitoring Team requested a current status of the usage of benzodiazepines, and was provided a copy of the pharmacy's monthly data tracking sheet, and summary for benzodiazepine usage, that indicated 29 individuals were prescribed a benzodiazepine containing medication for psychotropic indication on 7/1/2014, compared to 26 individuals in July 2013 The analysis indicated that no new prescriptions for benzodiazepines were generated for individuals who had resided at the Facility, but four individuals who moved into the Facility were continued on their transfer medications, which included benzodiazepines. Systems review for polypharmacy usage: The Facility continues to conduct monthly polypharmacy meetings, and reports are generated for the quarterly P&TC meetings. The Facility also reports and discusses polypharmacy usage, quarterly, at the QA/QI	

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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>Council data review meeting. 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.

Specific to psychiatric polypharmacy, the 7/22/2014 QA/QI data meeting minutes indicated the following polypharmacy usage:

<table>
<tr><td></td><td>6/2014</td><td>12/2013</td></tr>
<tr><td>Intra-class polypharmacy</td><td>20</td><td>17</td></tr>
<tr><td>Three psychotropic medications</td><td>55</td><td>55</td></tr>
<tr><td>Four psychotropic medications</td><td>11</td><td>11</td></tr>
<tr><td>Five psychotropic medications</td><td>3</td><td>1</td></tr>
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The Facility's analysis of polypharmacy usage indicated that between 1/2014 and 5/2014, there were six admissions to the Facility that were admitted on psychiatric polypharmacy, and five of the six were admitted on three or more psychotropic medications. The analysis also delineated the Facility's polypharmacy reduction plan for seven individuals who are currently being transitioned to lesser polypharmacy usage.

Conclusion:
The Facility documented an adequate review of polypharmacy, benzodiazepine, anticholinergic and stat chemical restraint usage, and clinically appropriate review of metabolic syndrome, and is in substantial compliance with Section N.3.</td><td></td></tr>
<tr><td>N4</td><td>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.</td><td>To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the QDRRs for Section N.2 of this report.

Review of the QDRRs for Individuals 701, #90, #660, #19, #79, #180, #351, #705, #474, #170 indicated the following:
• When clinically appropriate, the pharmacist documents specific recommendations on the QDRRs.
• In ten out of ten examples (100%), the medical practitioner documented review and acceptance of the pharmacist's recommendations.</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Conclusion: Because the medical provider reviewed, and accepted the pharmacist's recommendations, per review of ten QDRRs, the Facility remains in substantial compliance with Section N.4.	
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. For Section N.3, of this report, the Monitoring Team reviewed a total of 18 MOSES and 16 DISCUS assessments that were provided for Individuals #703, #90, #66, #19, #79, 180, 351, #474, #705, and #170. In addition, the Monitoring Team requested all MOSES and DISCUS assessments that were completed during this review period, for individuals who were prescribed a new neuroleptic and whose neuroleptic dose was decreased or discontinued, and was provided a total of 27 MOSES and 33 DISCUS assessments for Individuals #580, #666, #251, #18, #131, #371, #774, #702, #388, and #703. Therefore, a total of 45 MOSES and 49 DISCUS assessments were reviewed. • In 45 out of 45 MOSES assessments (100%) there was evidence that the prescriber signed and dated the MOSES assessment. • In 40 out of 45 MOSES assessments (89%), the physician completed the physician component of the MOSES assessment. • In 49 out of 49 DISCUS assessments (100%) there was evidence that the prescriber signed and dated the DISCUS assessment. • In 34 out of 49 DISCUS assessment (69%), the evaluation and physician component was appropriately completed. • For the ten examples that indicated a change in neuroleptic dose, eight out of ten (80%) indicated more frequent side effect monitoring by MOSES and DISCUS. Upon review of DISCUS assessments that indicated a diagnosis of TD, the Monitoring Team was concerned over the appropriateness of the completion of the DISCUS assessment. For example: • Individual #131: o DISCUS 1/22/2014: Total score was rated as five; however, the evaluation indicated a total score less then five. o DISCUS 2/24/2014: Total score was rated as five, and the evaluation component indicated a total score of less then five. Also, the DISCUS reported that the 1/24/2014 DISCUS was rated as a five. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team was provided a 1/22/2014 DISCUS, which was rated as a five. o DISCUS 4/11/2014: Total score was rated as five, and the evaluation component indicated a total score of less then five; also indicated that the DISCUS score from 2/24/2014 was four, when it was rated as a five. o DISCUS 6/18/2014: Total score was rated as five, and the evaluation component indicated a total score of less then five; also indicated that the DISCUS score from 4/11/2014 was four, when it was rated as a five. o For all DISCUS assessments provided for this Individual, the evaluation component did not indicate if there was, or was not a component of an underlying diagnosis, other then medication related. • Individual #702: o DISCUS 1/17/2014 indicated a total score of one, and the physician documented under the comment section "improved speech, others able to understand (the individual's) speech better since last medication change; continue to have some amount of ESP movements as previous evaluation. No change noted". The DISCUS assessments dated 2/18/2014, and 2/21/2014 indicated a total DISCUS score of five. The evaluation section indicated that the total score was less then five, and the physician did not document this significant change under the comment section; in fact, the physician documented the exact same statements as documented on the 1/17/2014 DISCUS assessment. o The DISCUS assessments dated 2/27/2014, 3/5/2014, 4/2/2014, and 4/30/2014 indicated a total score of 5; however, the evaluation component indicated that the score was less then five; furthermore, the physician did not document under the comment section, despite persistent TD. The physician should briefly indicate the cause of the TD, and clinical plan. o For all DISCUS assessments provided for this Individual, the evaluation component did not indicate if there was, or was not a component of an underlying diagnosis, other than medication related. However, there was one area of decline that must be addressed to retain compliance. The Facility must enhance completion of the evaluation and physician component of the DISCUS assessments. Summary: Per the last compliance report, the Monitoring Team was concerned that the Facility did not ensure more frequent monitoring for TD following the change in dose of a neuroleptic. During this compliance period, 80% of the examples reviewed demonstrated more frequent monitoring for TD following a change in neuroleptic dose. Therefore, this provision is found in substantial compliance. However, to retain this	

#	Provision	Assessment of Status	Compliance
		compliance rating, the Facility must enhance completion of the evaluation and physician component of the 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.	To assess the Facility's ADR process, the Monitoring Team reviewed the first ten ADRs that occurred beginning 1/21/2014 through 7/20/2014; and all data, trends analysis, summary review, and committee meeting minutes related to a system review of ADRs at the Facility. For the past six months period, the Facility's spreadsheet for ADR tracking database, dated 1/2014 through 7/2014, indicated a total of 24 potential ADRs were reported to the pharmacy department, and after review by the clinical pharmacist it was determined that a total of nine ADRs occurred during this period. Pharmacy review of ADRs include review of suspected medication, staff who reported the ADR, the clinical manifestation of the ADR, and if the ADR occurred within a hospital setting, or at the Facility. For all nine ADRs (100%), the pharmacy's data tracking form indicated that the medication was discontinued. All ADRs were reviewed by the pharmacist, who developed data analyses and summaries of the ADRs, which were then presented to the P&TC for further review. Review of the 7/22/2014 P&TC meeting minutes indicated a robust review, and discussion of identified ADRs. Of the 24 suspected ADRs, the physician reported seven out of the 24 (29%) cases, direct care staff reported four out of 24 (17%) cases, nursing staff reported two out of 24 (8%), pharmacists reported 5 out of 24 (21%), 4 out of 24 (17%) were reported by outside hospitals, and for two out of 24 (8%) potential ADRs reported, the original initiation of the ADR was not listed. The Monitoring Team reviewed training rosters for direct care staff on the reporting of ADRs, and indicated that 100% of direct service providers were trained on the ADR process. The pharmacy director reported that all nursing staff, physicians, and pharmacy staff have been trained on the ADR process. The Monitoring Team reviewed all nine ADRs that occurred during the reporting period (Individuals #527, #59, #631, #94, #706, #319, #581, #365, and #502): • Seven out of nine ADRs (77%) were reported using the ADR reporting form, at the time of identifying the ADR. • Nine out of nine ADRs (100%) were assessed by either the medical provider or nurse. • Nine out of nine ADRs (100%) were reviewed by the pharmacy department.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• The severity index was completed on the ADR form in four out of nine (44%) cases. • A description of the clinical findings was reported on the ADR form in nine out of nine (100%) cases. • The type of treatment provided for the ADR was documented on the ADR form in seven out of nine (77%) cases. • The indication of the offending medication was documented on the ADR form in nine out of nine (100%) cases. • Nine out of nine ADRs (100%) were reported at the P&TC committee. Three cases indicated issues of concern: • Individual #527: The ADR reporting form was dated 2/26/2014, for an ADR that occurred on 2/15/2014. The ADR form did not list all of the medical treatments provided; not commenting on the need for monitoring of oxygen saturations levels, and administration of nebulizer treatments. Several components of the ADR form were not completed. Despite the significant ADR manifestations, which included raised, spreading rash, and respiratory signs, there was no documentation of a medical provider's examining of the Individual, and there were no specific monitoring, and reporting parameters provided to direct care staff and nursing staff to monitor for further worsening. The signs and symptoms reported for this ADR warranted very close clinical monitoring, which was not evident by the IPNs provided for review. The pharmacist completed a single patient drug intervention report on 3/11/2014. • Individual #581: Following a QDRR review by the clinical pharmacists, an ADR report form was completed on 7/7/2014, for a suspected ADR that occurred on 4/14/2014. A medical provider suspected a possible ADR secondary to Namenda; however, the ADR report was not initiated by the medical provider until prompted by the clinical pharmacist. Given that the clinical manifestations were determined to be severe, more prompt reporting of the ADR should have occurred. • Individual #365: The Individual was administered diphenhydramine for bilateral redness to the forearms, and Augmentin was discontinued on 6/20/2014, and there was a detailed medical provider's IPN, dated 6/21/2014, documenting a possible allergic reaction to Augmentin. An ADR form was not completed until 6/27/2014, when prompted by the pharmacists. The Facility should ensure prompt reporting of ADRs, at the time an ADR is suspected. Although these examples indicated some lack of timeliness (with one of the three being significantly late), they also demonstrated that the QDRR process and pharmacist review ensured they were addressed.	

#	Provision	Assessment of Status	Compliance
		Conclusion: The Facility meets substantial compliance for its ADR process; however, the Monitoring Team strongly recommends that the Facility enhance follow-up by medical providers, and ensure that the reporting of all ADRs occurs at the time of identifying an ADR.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	To assess the Facility's drug utilization evaluation process (DUE), the Monitoring Team reviewed the following documents: • Drug utilization evaluation (DUE) schedule, for this reporting period • Copy of DUE developed and implemented for Diastat • Copy of all scheduled DUEs that were developed for this reporting period. Review of the pharmacy department's schedule for DUEs indicated that during the review period at total of three planed DUEs were initiated: Diastat, Lithium, and Bisacodyl. In addition, the pharmacy provided 12 unplanned DUEs, which were secondary to FDA advisories and clinical need by the Facility. The Monitoring Team reviewed the Facility's DUE for Diastat, and noted a comprehensive clinical review of usage at the Facility, as well as a comprehensive, and clinically meaningful literature review of the pharmacological treatment for seizure disorder, including the use of benzodiazepines such as Diastat. In addition, the DUE for Diastat resulted in a significant change in prescribing parameters, to ensure appropriate dosing of Diastat. The Monitoring Team is aware that at least one individual, Individual #719 had an active adverse drug reaction alert for benzodiazepines, and was prescribed and administered Diastat, and this issue was not discussed as part of the DUE for Diastat. Furthermore, the same Individual had documented clinical conditions, including a diagnosis of asthma, and recent diagnosis of influenza, both of which are considered potentially to result in respiratory compromise, and therefore a potential medical contraindication to the use of benzodiazepine class of medications. Both, the reported drug contraindication, and the potential medical contraindications should have been commented on within the context of the DUE. The Monitoring Team would like to make it clear that having a drug contraindication, or medical condition that might result in adverse outcome, is not a definitive reason not to administer Diastat; however, its prn use should be considered in the context of the IDT, and its usage should be well delineated by the prescribing medical provider. Conclusion: Because the Facility conducts clinically relevant DUEs when scheduled and when clinically necessary, the Facility continues substantial compliance with Section N.7.	Substantial Compliance

#	Provision	Assessment of Status	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 reviewed the Facility's medication variance process by reviewing medication variance data and trends analysis; medication variance committee minutes for May 2014, June 2014, and July 2104; medication variance report forms Individuals #376, #626, #28, #520, #492, #779, #88, #499, #131, and #394; and the DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 04.01.04. Compliance issues were also reviewed as a component for Provision M.6, and the reader is referred to that section for additional insight into the Facility's medication variance process. From a list of all reported medication variances that occurred during the review period, the Monitoring Team reviewed the medication variance reports for the first, and then every second individual, for a total of ten examples (Individuals #376, #626, #28, #520, #492, #779, #88, #499, #131, and #394): • The Medication Variance forms were fully completed, and indicated the type of variance, severity index, physician notification, and review by the department supervisor, in ten out of ten (100%) examples. • The department supervisor documented appropriate corrective action in ten out of ten (100%) examples. • The pharmacy department reviewed, and commented on ten out of ten (100%) examples. • Medication variances were incorporated into the medication variance database, and after analysis were presented to the medication variance committee for review in ten out of ten (100%) examples. The Facility continued to implement and maintain a robust database to track and trend medication variances. Medication variances were well classified by severity and by specific medical, pharmacy, dental, nursing, and "other" departments. There were a total of 1,137 variances reported from January 2014 through June 2014; 868 variances were category A, 32 were category B, 226 were category C, and 11 were category D. The reader is referred to Provision M.6, for a comprehensive breakdown of all reported medical variances. The medication variance committee meeting minutes for May 2014 through July 2014 reflected a comprehensive trends analysis, along with documentation of specific action plans that were developed and implemented to appropriately address medication variance, and there was documentation to indicate that the action plans were followed through complete implementation. The Facility updated its DSSLC Medication Variance Tracking and Procedures, Pharmacy Policy, Number 04.01.04 on 2/26/2014, and upon review, the Monitoring Team noted	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		that the Facility had followed its policy for its tracking, trending, and reporting on medication variances. The Facility's medical director, pharmacy director, and nursing director, in addition to other disciplines, including the director of residential services and director of quality assurance, all participate at the monthly medication review committee, and document their respective department's medication variance issues on the medication variance committee meeting minutes, including remediation action, and necessary system improvement initiatives. Conclusion: The Facility continued to implement and maintain a robust process to track, trend, analyze, and implement corrective action, when necessary, for medication variances. The Facility's database for tracking medication variances is robust, and not only delineates the severity of variances, but identifies the relevant department, and staff member who was responsible for the variance. The medication variance committee consists of leadership from all relevant departments, including nursing, pharmacy, and medical. There was evidence to indicate meaningful action steps to help mitigate medication variances in the future. The Monitoring Team compliments the Facility for developing, implementing and maintaining a robust medication variances process, and determined that the Facility is in substantial compliance with Provision N8.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: 1. DSSLC Self Assessment 7/3/2014 2. DSSLC Action Plan (undated) 3. Presentation Book for Section I, Section O, and Section P 4. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 3/3/14) 5. DSSLC Policy CMGMT 34 Occupational/Physical Therapy Services (rev 3/3/14) 6. DSSLC PNMT Process Flow Chart (10/17/13) 7. Universal Monitoring Plan rev: 3/15/13 8. Record reviews: a. Sample O.1: Individuals #66, #167, #463, #551, #553, #743, #749, #752 and #776 b. Sample O.2: Individuals #517, #565, #576, and #590 c. Sample O.3: Individuals #5, #28, #82, #89, and #690 d. Sample O.4: Individuals #32, #247, #379, and #463 e. Sample O.5: individuals #13, #33, #45, #52, #55, #94, #144, #189, #221, #357, #373, #395, #398, #487, #507, #532, #664, #674, #669, #705, #759, and #787 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 10. A list of continuing education sessions or activities participated in by PNMT members since last review (1/2014) 11. Minutes, including documentation of attendance, for the Physical and Nutritional Management Team (PNMT) and Physical and Nutritional Management Committee (PNMC) meetings for the past 6 months 12. Individual PNMT reports as available for individuals reviewed above 13. A list of PNM assessments and updates completed in the last quarter 14. Individual Support Plans (ISPs) for all sample individuals 15. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 16. Tools used to monitor implementation of PNM procedures and plans 17. A list of individuals for whom PNM monitoring tools were completed in the last quarter 18. Tools utilized for validation of PNM monitoring 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 20. PNMP template and any instructions for use of template 21. PNM spreadsheets generated by the Facility 22. Lists of individuals: a. On modified diets/thickened liquids; b. With BMI equal to greater than 30; c. With BMI equal to less than 20;

	d. Since October 2012, who have had unplanned weight loss of 10% or greater over six (6) months; e. During the past six months, have had a choking incident; f. During the past six months, have had a pneumonia incident; g. During the past six months, have had skin breakdown; h. During the past six months, have had a fall; i. During the past six months, have had a fecal impaction; j. Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); k. With poor oral hygiene; and l. Who receive nutrition through non-oral methods 23. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 24. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 25. Tools and checklists used to provide competency-based training addressing: a. Foundational skills in PNM; and b. Individual PNM and Dining Plans 26. Physical and Nutritional Management Related Training Data **People Interviewed:** 1. Paula Horn PT- Director of Habilitation Therapies (HT) 2. Becky Nurre CCC-SLP Speech Director 3. Jean Mykietyn OTR, PNMT Lead 4. Stacy Krause PNMT RN 5. Erin O'Toole PNMT SLP 6. Six direct care professionals (DCPs) (Cedar Falls, Timberhill, and Westridge) **Meeting Attended/Observations:** 1. Physical and Nutritional Management Team (PNMT) 7/21/14 2. Mealtimes, Medication Administration, and Transitions- Cedar Falls, Westridge and Timberhill 3. Change of Status Meeting—Individual #684
	Facility Self-Assessment: DSSLC's Self-Assessment, updated 7/3/14, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in substantial compliance with Sections O.1, O.2, O.3, O.5, and O.8 and not in compliance with Sections O.4, O.6, and O.7. This was not consistent with the Monitoring Team's findings of substantial compliance with Section O.1 and O.3 and noncompliance with Sections O.2, O.4, O.5, O.6, O.7 and O.8. 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. Overall, the Action Plans included relevant actions that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report. The 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. Overall, the Facility had demonstrated excellent use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed and ensuring the metrics reviewed are aligned with those identified in the Settlement Agreement.
	Summary of Monitor's Assessment: Many positives were noted within this Section. DSSLC continued to take steps forward with regards to the providing of Physical Nutritional Management (PNM) Services. The PNMT continued to show adequate review of individuals on caseload, but many times individuals who were having issues or had a significant history of PNM issues were not consistently provided the needed assessment or thorough review when not referred to the PNMT. These individuals were primarily reviewed by the IDT and lacked the thorough discussion needed to fully address signs, symptoms and associated risks. Additionally, there continued to be difficulty in transitioning and integrating information into the Integrated Health Care Plan. PNMPs were noted to remain comprehensive and provided staff with detailed strategies to mitigate associated PNM risks if followed. New Employee training was comprehensive and DSSLC provided annual or refresher trainings that focused on preventing aspiration and providing proper transfer and lifting. **Provision O.1:** This provision was determined to be in substantial compliance. An adequate Physical and Nutritional Management Team (PNMT) was now back in place as evidenced by consistent participation by the PT and the RD. 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. DSSLC continued to revise the PNMT policy so that it now included the expected collaboration with Dental. As with the previous visit, there was noted collaboration in practice with Dental as evidenced by a

	desensitization program that had recently been developed. **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 but still was lacking in its comprehensiveness and accuracy. 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. This was especially evident when the PNMT was not directly involved. **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. PNMPs across the various locations (i.e., MARs and "Me" books) were consistent and appropriately updated. **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. **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. **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. DSSLC was developing a new monitoring process in which the frequency of the monitoring would be determined on an individual basis and included as part of the IHCP and OT/PT assessment. This process will need to be reviewed once implemented. **Provision O.7:** This provision was determined to be not in compliance. There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized 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. **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 had shown significant improvement but lacking was consistent evidence of IDT review and acceptance prior to the initiation of the oral motor treatment program.

#	Provision	Assessment of Status	Compliance
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	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of nine individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of four individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of five individuals at DSSLC who received enteral nutrition. Some of these individuals might have been included in one of the other samples. Sample O.4 consisted of four individuals who were receiving oral motor therapy. Sample O.5 consisted of 22 individuals observed during times of transition as well as during times of intake. This provision was determined to be in substantial compliance. A Physical and Nutritional Management Team (PNMT) existed that consisted of the appropriate members. The PNMT now had a core physical therapist (PT), and the registered dietitian (RD) consistently attended the PNMT Core Meetings. DSSLC continued to utilize both a PNMT and 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. 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. A localized PNMT policy (DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy-rev	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	6/25/2014) 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. 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. **PNM Policy and Role of the PNMT:** The Facility did have evidence of a comprehensive PNM Policy. Now included as part of the PNM policy was information regarding collaboration with Dental. The PNM policy along with the PNMC policy and PNMT flow process contained the following components: • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide),	

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		○ Identification of monitors and their roles and responsibilities, ○ 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, ○ 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 ○ Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system included: ○ Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; ○ Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; ○ 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): ○ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). ○ Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and ○ If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. ○ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia. **<u>Core PNMT Membership</u>:** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate discipline membership as defined in the Settlement Agreement. DSSLC had identified the Registered Nurse (RN), 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. **<u>Consultation with Medical Providers and IDT Members</u>** For four of four individuals in Sample O.2 (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. For four of four 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	

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		meeting with the IDT; therefore, IDT members of the individuals discussed were consistently involved in the meetings. **Qualifications of PNMT Members** Five of five core PNMT members (100%) were licensed to practice in the state of Texas and five of five PNMT Members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. **Qualifications of Back-Up PNMT Members** Five of five back-up PNMT members (100%) were licensed to practice in the state of Texas and all back-up PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. **Continuing Education** 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. Five of five 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: • Pneumonia • Surgical Intervention for Dysphagia • Counseling Theories and Skills for SLPs • The Source for Dysphagia - Third Edition • Airway Clearance Seminar **PNMT Meetings** From 12/1/2013 to 5/31/2014, of the 26 weeks, the PNMT met 26 of 26 weeks at a minimum of once weekly (100%) with some weeks meeting more than once. Based upon review of the PNMT signature sheets, attendance for the PNMT meetings were as follows: • OT: 99% • SLP: 94% • PT: 92% • RN: 99% • RD: 99% All core members of the PNMT were present for at least 80% of the meetings and with the backups attendance was over 90% for all disciplines.	

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		Thirteen of the 13 PNMT meeting minutes reviewed for Samples O.1 and O.2 (100%) included documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The Facility PNMC did have a sustainable system fully implemented for resolution of systemic issues/concerns. The PNMC met a minimum of monthly. The purpose of the PNMC was to: 1. Identify systemic PNM and clinical issues through: a. Review of facility data related to PNM b. Reports from PNMT, IMRT, QA/QI, Medical, Dental, and nursing committees 2. Develop action plans to address systemic PNM and clinical issues 3. Monitor/review data to determine effectiveness of action plans Per review of the PNMC minutes from 12/1/2014 to 5/31/2014 there was evidence that the PNMC reviewed systemic issues at DSSLC. Among the issues discussed included: • Fall prevention • Occurrence of pneumonia • Other issues related to dysphagia, oral hygiene, mobility and skin integrity Members of the PNMC included: • Facility Director-Nancy Condon • Assistant Director of Programs-Dora Tillis • Medical Director-Dr. Stanley Cal • Habilitation Therapies Director-Paula Horn • Chief Nurse Executive-Delia Schilder • Nurse Operations Officer-Sherri Courtney • PNMT Occupational Therapist-Jean Myketlyn • QA Director-Lori Powell PNMC attendance was reviewed from 12/1/2014 to 5/31/2014 and found attendance was satisfactory as all members of the PNMC had an attendance record of greater than 85%. The PNMC in collaboration with the QA department had developed clinical indicators that assisted DSSLC in establishing facility systemic trends. Among the clinical indicators that continued to be reviewed by the PNMC on a monthly basis were: • Hospitalizations • ER visits • Deaths • Skin Integrity	

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		• Enteral Nutrition • Aspiration Pneumonia • Pneumonia • Falls • Diabetes Management Report • Individuals followed by PNMT and the PNMT's level of involvement • UTIs • Pseudomonas	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems	**Identification of PNM risk** Four hundred thirty-six of 436 individuals (100%) 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 other individuals residing at DSSLC did not have PNM issues and therefore did not have PNMPs. The Facility had a sustainable system to maintain and update lists of each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"). DSSLC 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. Seven of ten individuals in Sample O.1 (70%) 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). An example of an individual not being rated for risk appropriately was Individual #66 who was identified multiple times as having weak and fragile bones but was only listed as being at a medium risk of fractures however, it should be noted that the IRRF clearly delineated all necessary supports and services to help mitigate the risks associated with the individual's recurrent pneumonia. Another example was Individual #684 who was not included as part of the overall Sample O.1 but was added to this metric as the Monitoring Team attended the Change of Status (CoS) meeting. Issues with the CoS meeting were as follows: • The team did not increase the risk of aspiration pneumonia although he individual was being provided with oral stimulators that would increase saliva. Individual #684 was known to silently aspirate on thin liquids. Additionally, the risk of bacterial pneumonia was increased due to poor infection control procedures. (i.e., not having a clear process in place to ensure oral stimulators remained clean) • IDT did not increase GI risk although objects ingested in the past have required removal.	Noncompliance

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	to identify the causes of such problems.	Team stated that Bowel Obstruction was already high so why increase this one too. • No increase in Behavior although PICA behavior has increased. IDT stated "why increase his risk when it is our problem that he is having increased PICA?" **<u>Physical and Nutritional Management Team Referral Process</u>** Nine of nine individuals (100%) from Sample 0.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. The facility policy stated that at a minimum, the PNMT RN would assess individuals diagnosed with: • Aspiration Pneumonia • Recurrent Pneumonia • GI Issues • Fractures • Skin Integrity Issues • Seizures The PNMT would always review: • Initial or proposed enteral tube placements • Aspiration Pneumonias • Choking incidents requiring physical intervention • Significant unplanned weight loss • Recurrent Pneumonia • Fractures of long bone, skull or hip • Unresolved vomiting • Delayed healing of Stage 2 or Stage 3 or 4 decubitus The concern noted was that unless it was identified as an Aspiration Pneumonia, other types of pneumonias (i.e., bacterial) were not consistently reviewed and investigated by the PNMT and/or IDT. For example, Individuals #66 and #776 both were diagnosed with bacterial pneumonias and received limited to no review of potential causes of the event. When considering the above, only two of six who experienced pneumonia (33%) were referred to or reviewed by the PNMT. In nine of nine individual records reviewed from Sample 0.1 (100%), when an individual experienced a change in status that would initiate a referral (according to policy) 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. Again, the concern was that only 33% who were diagnosed with a non-aspiration related pneumonia were reviewed/referred by the PNMT 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	

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		needed then the IDT was contacted so that a joint meeting would occur to discuss the findings of the assessment, concerns of the PNMT, and how the PNMT could support the IDT by providing a focused or full assessment or by merely discussing the issue and providing guidance to the individual's IDT. As a result, initiation and receipt of the referral occurred simultaneously and was within five working days. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT members in the IRT, IMRT and Integrated Morning Report meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. 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. Two individuals from Sample O.1 received a feeding tube (not on an emergency basis) since the last review. Per review of the PNMT minutes, there was evidence of PNMT discussion prior to receiving the feeding tube. No individuals at DSSLC received an emergency feeding tube placement since the last review. **PNMT Assessment** Four of four 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. Two of four assessments/reviews sampled (50%) led to a full assessment. The two individuals not listed in this sample were discussed by the PNMT in response to a hospital return. One of one PNMT assessments completed in Sample O.2 (100%) was completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. The need for full comprehensive assessments was based upon discussion of the incident and assessment of the situations surrounding the PNM event. Per interview with the Director of Habilitation Therapies, based on the findings and results of discussion, the PNMT then makes the determination of whether a comprehensive assessment was needed. When a full assessment was not warranted, all relevant assessments (i.e., Nutritional, Habilitation) were reviewed for relevance and	

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		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. Based on review of individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment/review components were as follows: • One of one (100%) contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment. The three individuals not listed in this sample were reviewed by the PNMT in response to a hospital return but did not have a full assessment. • Four of four (100%) contained date assessment/review was initiated. This information was contained within the PNMT assessment, PNMT minutes, or Habilitation Therapies Assessments. • Four of four (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment. • Four of four (100%) identified the individual's current risk rating(s), including the current rationale. This information was contained within the IRRF, Habilitation Therapy Assessments, and/or PNMT evaluation as indicated. • Four of four (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. This information was contained within the IRRF, ISPA, Habilitation Therapy Assessments, and/or PNMT evaluation as indicated. • Four of four (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. • Four of four (100%) contained assessment/review 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.). • Four of four (100%) contained assessment/review of musculoskeletal status as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Four of four (100%) contained evaluation/review of motor skills as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Four of four (100%) contained evaluation/review of skin integrity as indicated by the PNMT RN Assessment, ISPA and the various PNM related assessments (Habilitation, Nutrition, etc.). • Four of four (100%) contained evaluation/review 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. • Four of four (100%) contained evaluation/review of current adaptive equipment. This information was contained within the Habilitation Assessment as well as the PNMT minutes.	

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		• Four of four (100%) contained nutritional assessment/review, 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. • One of four (25%) contained evaluation/review 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. • Zero of two (0%) who received enteral nutrition had identified residual thresholds, for return to the PNMT. • 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. • Four of four (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Three of four (75%) 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. • Zero of four (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component when there was not a formal PNMT referral and evaluation. • Four of four (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. • Zero of four (0%) 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. • Four of four (100%) contained evidence of observation of the individuals' supports at their home and day/work programs. • Four of four (100%) contained evidence that the PNMT conducted hands-on assessment and/or review. • Four of four (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. • Four of four (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	

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		Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Four of four (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. • Two of four (50%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This information was not noted within the Habilitation Assessment or as part of the PNMT Assessment, and PNMT minutes. Concerns were noted regarding the availability of the thresholds for Individuals #517 and #590 as their thresholds were not included as part of the ISP or as part of the IHCP resulting in them not being readily available for staff review and knowledge. The other two individuals in this sample did not have evidence of the standard thresholds being discussed or integrated as part of the above mentioned plans (ISP and IHCP) while more specific thresholds were developed. • Four of four (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (e.g. revision of the individual's PNMP). • Zero of four (0%) contained recommendations for monitoring, tracking or follow-up by the PNMT/IDT. While there were recommendations noted as part of the PNMT assessment and imbedded within the PNMT minutes, there was little to no evidence of: o Recommendations for follow up by the PNMT to determine if recommendations to the IDT were completed and if they were effective in mitigating the identified risks or concerns. o Sharing of recommendations when there was no a formal PNMT assessment • Four of four (100%) contained signatures with dates. Overall, the concern noted was that there was little evidence of the IDT discussing all relevant factors that could be impacted by the significant change if there was not a formal PNMT evaluation. In order to understand the etiology of the PNM event, one must review all indicators for potential impact. Additionally, as mentioned previously, there was a lack of discussion and root cause analysis if the pneumonia event was not diagnosed as resulting from aspiration. 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 and that there is evidence of root cause analysis for all pneumonias. Examples of concerns regarding lack of review are: • Individuals #66, #776 and #551 were all diagnosed with bacterial pneumonias in the months leading up to the aspiration pneumonia but were provided with limited to no review or root cause analysis. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>**	

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		For zero of four 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: • Thresholds were not integrated into the IHCPs 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 but positive outcomes of the CAP have not been noted. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In four of four (100%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment/review. • For three of three individuals (100%) for whom Head of Bed Evaluations (HOBE) assessments were conducted, the HOBE recommendations were integrated into individuals' plans. • In four of four (100%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In one of four (25%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. This was only noted as present for the individual who received a formal PNMT assessment. This information was not contained as part of the ISPA when there was no formal PNMT participation. • In zero of four (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 information was not included as part of the IHCP. • In one of four (25%) individuals' plans reviewed, the plans defined triggers as indicated. This only occurred when the individual was provided with a formal PNMT evaluation. • In zero of four individuals' plans reviewed (0%), the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation for individuals in Sample O.2: • In zero of four (0%) 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. • In zero of four (0%) 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. For example, as part of the action plan for Individual #565, it was recommended on 5/14/14 to add	

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		Dysphagia to the active problem list and for dental to provide staff training. As of 6/9/14, neither one of these had been completed. **<u>Individuals Discharged from the PNMT</u>** For individuals discharged by the PNMT in Sample O.2: ▪ 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. ▪ One of one individual's (100%) discharge summaries/action plans provided objective clinical data to justify the discharge. ▪ Zero of one individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ One of one individual's 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. The issue was that the thresholds were not integrated in the IHCP. 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, and objective clinical data to justify the discharge existed. Missing was a process to ensure criteria for referral back to the PNMT were integrated as part of the IHCP.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate 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	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 continued to be appropriate. **<u>Identification of Individuals Requiring a PNMP</u>** For the thirteen individuals in Sample O.1 and O.2, 13 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 13 of 13 (100%) individuals. the disciplines noted during the pre-ISP were present at the annual ISP meeting. 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. This was at a minimum provided with the majority of meetings having more than one discipline present. Thirteen of 13 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	Substantial Compliance

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	individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	required to the PNMP. Four hundred and thirty six of 436 individuals (100%) 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. **PNMP Format and Content** A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 13 of 13 individuals (100%) were current within the last 12 months. • PNMPs for 13 of 13 individuals (100%) included a list of all high-risk levels and individual triggers as indicated. • In 13 of 13 most current PNMPs (100%), there were large and clear color photographs with instructions. • Thirteen of 13 PNMPs (100%) listed the adaptive equipment required by the individual. Rationale regarding the need for the adaptive equipment was not present on the PNMP but was available as part of the Habilitation Therapy assessments. • In 13 of 13 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 13 of 13 PNMPs (100%), positioning was adequately described per the individuals' assessments. • In 13 of 13 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 13 of 13 PNMPs (100%), bathing instructions were provided. • In 13 of 13 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 13 of 13 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning, or the individual was described as independent. • In 13 of 13 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • Thirteen of 13 individuals' (100%) Dining Plans were current within the last 12 months. • Six individuals had feeding tubes with no oral intake. Six of six (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 13 of 13 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In seven of seven PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In seven of seven PNMPs/dining plans for individuals who received liquids orally (100%),	

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		the liquid consistency was clearly identified. • In seven of seven PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 13 of 13 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 13 of 13 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • Thirteen of 13 PNMPs (100%) included information related to communication (how individual communicated, how staff should communicate with individual). Missing from the communication section was detailed information on how the person communicated as well as how staff should bridge communication. **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For five 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. For individuals for whom the PNMP was revised, there was supporting documentation that five of five individuals' (Sample O.1) revised PNMPs (100%) had been implemented. 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.	
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	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** Staff did not engage in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, 14 of 22 individuals' (64%) dining plans/PNMPs for Sample O.5 were implemented as written. Examples of dining plans not implemented included but were not limited to: • Individual #45 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. • Individual #221 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. • Individual #664 was observed with poor positioning with face laying sideways in his food with no cues from staff to elevate head and neck.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.</td><td>

Individual #395 was observed taking extremely large bites with no cues to take small bites and no liquids offered until she had completed half her meal.
Individual #787 was observed receiving her liquids in a cup ½ full as stated in the PNMP but was allowed to gulp the ½ cup with no cues.
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. Failure to implement this Individual's PNMP has now been noted for three consecutive compliance visits.
Individual #487 was observed poorly positioned with hips forward resulting in a poor seat to back angle.

Transfers were improved and observations noted:

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

During four of four observations 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.

<u>Knowledge of Staff Regarding PNMPs</u>
Staff Interview: Staff were not consistently knowledgeable of the individuals' PNMPs. Based upon interviews with six staff from Timberhill, Cedar Falls, and Garden Ridge, knowledge of staff had improved from the previous visit. Following are the numbers of staff who answered correctly and the number asked the question:
<table>
<tr><th></th><th># Asked</th><th># Correct</th><th>% Correct</th></tr>
<tr><td>Positioning:</td><td></td><td></td><td></td></tr>
<tr><td>How do you know the individual is in the correct position in their wheelchair/bed?</td><td>6</td><td>5</td><td>83%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
<tr><td>For what reason does the individual have thickened liquids?</td><td>6</td><td>6</td><td>100%</td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>6</td><td>6</td><td>100%</td></tr>
<tr><td>What is the reason for the individual using a specific utensil?</td><td>6</td><td>4</td><td>67%</td></tr>
<tr><td>If the individual receives enteral nutrition,</td><td>6</td><td>4</td><td>67%</td></tr>
</table>
</td><td></td></tr>
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		how do you determine if he/she is in the correct position?	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	**New Employee Orientation (NEO)** The PNM related core competencies (i.e., foundational skills) were comprehensive. NEO orientation included the following elements: ▪ Physical Management and Mealtime Training ▪ Lifting People, Transfers and Assistive Equipment ▪ Preventing Aspiration The large majority of staff successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs. Per DSSLC training records, the following percentage of staff had received and successfully passed all NEO trainings and were current with their annual refresher courses were as follows. • Lifting People-1014/1045 (97%) • Physical Management-1281/1281 (100%) • Preventing Aspiration/Mealtime Training-1281/1281 (100%) **PNM Core Competencies for Current Staff** 100% of staff responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. Staff responsible for providing training included OTs. COTAs, PTs, PTAs, SLPs, SLPAs, PNMP coordinators and Competency, Training and Development Staff. These staff included those who were responsible for training the following courses: ▪ Mealtime ▪ Physical Management ▪ Lifting People **Annual Refresher Training** As of 6/30/14, staff who require training had completed annual refresher competency-based training and performance check-offs within the last 12 months. ▪ Lifting People: 273 of 316 (86%) completion rate ▪ Preventing Aspiration/Mealtime: 415 of 461 (90%) completion rate Per PNM policy, training will be provided at least annually and as indicated by monitoring. **Individual-Specific Training** There was 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. Staff responsible for the additional non-	Noncompliance

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		foundational training included OTs. COTAs, PTs, PTAs, SLPs, SLPAs, and PNMP coordinators. A process did exist 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 had completed the development of a three-level system that categorized individuals into three levels of need and required different levels of staff training in order to work with the individual. The levels were as follows: • Level 1: These individuals have PNMP information/techniques that are such that, if staff does not respond in exactly the right way, there is a very high risk of serious injury or other serious negative outcome to the person served. These individuals have a PNMP which is so specialized that it incorporates very specific techniques(s) that is/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. • Level 2: These individuals have PNMPs that are specialized but use techniques that are taught and competency assessed in the general Habilitation lifting/Positioning, PNMP training, and/or monitoring training. Staff need to know which skills to use and may need to have experience using the skills, but would not have to learn new skills to use the plan. Staff would know how to implement by reading the plan and having a chance to ask questions for clarification. • Level 3: These individuals either do not have a PNMP or have a simple PNMP with no specialized instructions. The individual's levels were determined based on consultation by the Director of Habilitation Therapies and other professional staff. As of this review, there were no individuals categorized as Level 1 and five individuals categorized as Level 2. To determine whether the Facility implemented the process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed four individuals identified by DSSLC as being Level 2 priority which indicated the need for additional training and reviewed evidence that staff working with these individuals had received all the training related to PNM. Upon request of the evidence verifying training, DSSLC provided brief explanations stating that the need for these individual to receive non-foundational training was changed and therefore no longer was needed. The Monitoring Team requested evidence of this discussion and/or determination but none could be provided by DSSLC that substantiated these statements. Instead, DSSLC provided two other individuals who were not requested or on the list of individuals provided by DSSLC as requiring additional training. For these two individuals, there was evidence of Individual Specific	

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		Training.	
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** Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. Compliance was achieved with a score of 80% or higher unless it stated that implementation was not noted, then a score of "Noncompliance" was automatic. Monitoring tools included adequate instructions/guidelines. The State Supported Living Center Compliance Monitoring Form had guiding questions regarding what the staff conducting the monitoring should be considering and looking for, and included how training should be provided in the occurrence a deficiency was noted and how the information would be shared at the Incident Review Team (IRT). Per interview with the HT Director, review of monitoring data revealed the process for informing the IDT and developing corrective action plans based on monitoring information was not working due to the complexity of the process. During the first quarter of 2014, the process was re-assessed and a new process is now being developed by HT in which the frequency of monitors will be determined by the OT/PT/SLP and included as part of the OT/PT/SLP assessments. This frequency would then be included as part of the IHCP. Per interview, the HT director stated that all areas which are likely to provoke PNM difficulties would be addressed and represented. Once the frequency was established, the IDT would assign responsibilities and share that information with QA/QI. This process was just initiated so it could not be reviewed at this time. In order for this approach to be successful, DSSLC must ensure that all areas and all shifts are monitored and that Individuals who are at an increased risk receive more intensive monitoring. There must also be a process in place that is able to track the expected number of monitors and the timely completion of the monitors. 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: Per CMGMT-34-Occupational-Physical Therapy-Exhibit A-3/3/14, the QA/QI Department would calculate Inter-Rater reliability. 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.	Noncompliance

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		The above process was not implemented due to DSSLC being in the process of revising their monitoring system; therefore, this will need to be reviewed at a later date. A graph showing the approximate percentage of areas monitored for PNM during the months of January, February, March, April and June provided information as follows:	

	Bathing	Lifting/Transfer	Meal	Med Admin	Oral Care	Positioning	Snack	Communication
1/14	0%	0%	94%	0%	0%	6%	0%	0%
2/14	0%	0%	0%	0%	0%	0%	0%	0%
3/14	0%	0%	0%	0%	0%	0%	0%	100%
4/14	0%	0%	55%	0%	0%	40%	0%	5%
5/14	0%	3%	18%	0%	0%	7%	0%	72%
6/14	0%	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. Other issues noted included:

- Only 44 monitors were completed from Jan1, 2014 to June 2014.

In order to move towards substantial compliance, DSSLC will need to ensure that all areas that 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 the individual's assessment and/or plans/IHCPs did not specify clearly the level or frequency in which the person should be monitored in response to PNM related events.

The PNM policy (CMGMT 32-rev 6/25/14) 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. As stated previously, a new process was in its infancy in which the specific number would be determined as part of the OT/PT/SLP assessment but this has not been implemented as of the date of this report.

DSSLC was in the process of reviewing the system and developing new standards for effectiveness monitoring. The new process was as follows:

1. Habilitation therapist will monitor PNMP/DP effectiveness as recommended in the Habilitation Therapist's Assessment and identified in the ISP/IHCP to ensure the effectiveness of plans, proper implementation of interventions and staff knowledge,

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		appropriateness of equipment and supports, and challenge services and supports when indicated. 2. Monitoring schedules should take into consideration intensity of supports as well as the level of PNMP risks. 3. Program effectiveness monitoring must be completed on the activity-specific Universal Monitor Form and on an IPN (for the IDT to review) that must include: a. Any previous issues that remain unresolved; b. PNM Risk occurrences since previous effectiveness monitoring; c. Any documented PNM triggers documented on trigger data sheets; d. Presence and condition of equipment; e. Staff knowledge and staff/individual compliance f. Analysis of program effectiveness including progress, regression, and maintenance as well as if plans remains current and appropriate; g. Any identified issues with recommendations made including person responsible and timelines for completion. h. Completed effectiveness Universal Monitor Forms are submitted to the QA Department for data entry and tracking will be monitored through resolution if issues are identified 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.	
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.	**<u>IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans</u>** Thirteen of the 13 individuals' records for Samples O.1 and O.2 (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). Four of the 13 individuals' records in Samples O.1 and O.2 (31%) 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 mostly 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. It should be noted that the above percentage represents an improvement of 24% since the last review and per interview with Paula Horn HT director, the new QIDP director was focusing on improving this area.. The improvement noted was that the QIDP did a better job reviewing the expected outcomes of the PNMP (e.g., no pneumonias or choking events)	Noncompliance

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		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. Zero of four Trigger sheets (0%) were completed correctly. Zero of four Trigger sheets (0%) were reviewed at a minimum daily by the appropriate shift RN. Issues with the Aspiration Trigger Sheet included: • The trigger sheets contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing and Case Manager Review of the trigger sheet was inconsistent. • Triggers captured on the trigger sheet did not match triggers on the PNMP.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Evaluation of Individuals who receive Enteral Nutrition** The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. Five of five 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. Five of five individuals (100%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. Medical necessity was identified as part of the Nutritional Assessment, Habilitation Assessment, IRRF as well as part of the Aspiration Pneumonia and Enteral Nutrition (APEN). None of the 17 individuals who were admitted since the last review received enteral nourishment; therefore no individuals were reviewed to determine the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** Five of five individuals (100%) 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, PNMT minutes and included as part of the ISP.	Noncompliance

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		For individuals receiving oral motor therapy in Sample O.4, the following was noted: Four of the four individuals who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (100%) had a comprehensive plan outlining the treatment or return to PO process. Two of the four individuals' plans to return to oral eating were based on the results of the IDT's discussion (50%) and were integrated in the IHCP, ISP, and/or an ISPA. Individuals #463 and #379 did not have evidence of IDT discussion or integration. Two of the four individuals' plans to return to oral eating in the IHCP related to enteral nutrition (50%) were implemented in a timely manner. The Monitoring Team was unable to determine if the other two programs were implemented in a timely manner due to lack of evidence of IDT discussion and documentation of discussion. Four of four staff responsible for implementation of these oral intake plans (100%) were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. The implementation was only provided by the SLP and therefore staff was determined to be adequately trained. Four of the four individuals' plans (100%) were monitored as outlined in the plan. No plans were modified by the IDT so the Monitoring Team was unable to determine if the IDT met and interventions reviewed and modified as needed. In order to move towards substantial compliance, DSSLC must improve its documentation of IDT review and acceptance prior to the initiation of oral motor therapy.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** 1. DSSLC Self Assessment 7/3/2014 2. DSSLC Action Plan (undated) 3. Presentation Book for Section I, Section O, and Section P 4. DSSLC Policy CMGMT 32 Physical and Nutritional Management Policy (rev 3/3/14) 5. DSSLC Policy CMGMT 34 Occupational/Physical Therapy Services (rev 3/3/14) 6. Treatment Documentation Procedure (rev: 10/22/13) 7. Occupational/Physical Therapy Audit Process (rev: 11/8/13) 8. DSSLC PNMT Process Flow Chart (10/17/13) 9. Universal Monitoring Plan rev: 3/15/13 10. Wheelchair Repair Log (12/31/14 to 5/30/14) 11. Record reviews: a. Sample P.1: Individuals #66, #167, #463, #551, #553, #743, #749, #752 and #776 b. Sample P.2: Individuals #32, #55, #79, #243, #289, and #617 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 13. A list of continuing education sessions or activities participated in by PNMT members since last review (12/2013) 14. Current Lists of people: (a) Who use wheelchair as primary mobility; (b) With transport wheelchairs; (c) With other ambulation assistive devices, including the name of the device; (d) With orthotics and/or braces; (e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution; (f) Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury 8. OT/PT assessments template and guidelines 9. 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 10. List of individuals receiving direct OT and/or PT services and focus of intervention 11. List of ten individuals with the most falls since the last compliance review **People Interviewed:** 1. Paula Horn PT Director of Habilitation Therapies 2. Six DCPs (Cedar Falls, Timberhill, Westridge) **Meeting Attended/Observations:** 1. Physical and Nutritional Management Team 7/21/14

	2. Mealtimes and Transitions- Cedar Falls, Westridge, and Timberhill 3. Change of Status meeting-Individual #684
	Facility Self-Assessment: For Section P in conducting its self-assessment: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o This monitoring/audit tool did include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ The Facility rated itself as being in substantial compliance with Section P.1 and P.3 and not in compliance with Sections P.2 and P.4. This was inconsistent with the findings of noncompliance with Sections P.1-P.4. o P.1 showed improvement with the assessment but continued to lack the needed information as it related to the schedule of monitoring. o P.3 showed lack of a clear method in place to ensure staff are provided with the needed training. 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. 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: DSSLC continued to show improvement with services identified within this provision. The assessments continued to improve and provided a more comprehensive review of the individual. Indirect Supports (i.e., PNMPs) showed significant improvement and did a nice 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. **Provision P.1:** This provision was identified as being not in compliance. All areas within the assessment including but not limited to comparative analysis, inclusion of information regarding risk levels and how they impact functional skills and health status were noted to have continued improvement with the exception of the identification of the monitoring schedule. This was identified as needing to be improved in order to sustain substantial compliance but as of this review, the needed improvement has not been noted. Additionally, moving forward, the OT/PT assessment will contain the recommendations for overall effectiveness and compliance monitoring. This was not noted to be in effect at the time of the review and will need to be reviewed at a later date.

	Provision P.2: This provision was determined to be not in compliance. Monthly documentation from the OT and PT and/or QIDP 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. Additionally, indirect plans of care were not consistently implemented by staff. **Provision P.3:** This provision was determined to be not in compliance. There was no process in place to ensure OT/PT supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. **Provision P.4:** This provision was determined to be not in compliance. A formal monitoring system 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.	This provision was found to be noncompliant. All areas were noted to have continued improvement with the exception of the identification of the monitoring schedule. This was identified as needing to be improved in order to sustain substantial compliance but as of this review, the needed improvement has not been noted. Additionally, moving forward, the OT/PT assessment will contain the recommendations for overall effectiveness and compliance monitoring. This was not noted to be in effect at the time of the review and will need to be reviewed at a later date. Samples for this section were as follows: Sample P.1 is the same as Sample O.1 that consisted of a non-random sample of 12 individuals who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Sample P.2 consisted of six 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	Noncompliance

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		the therapy. **<u>Timeliness of Assessments</u>** Seventeen of 17 individuals (100%) admitted since the last review received a comprehensive OT/PT assessment within 30 days of admission and 5 business days of the ISP. 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. Fifteen of 15 individuals' OT/PT assessments in Samples P.1 and P.2 (100%) were dated as having been completed at least 10 business days prior to the annual ISP. Fifteen of 15 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. **<u>OT/PT Assessment</u>** 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: • Fifteen of 15 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Fifteen of 15 assessments (100%) included diagnoses and relevance to functional status. • Fifteen of 15 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. • Thirteen of 15 assessments (87%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Fifteen of 15 individuals' OT/PT assessments (100%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Fifteen of 15 assessments (100%) included medical history and relevance to functional status. • Fifteen of 15 assessments (100%) addressed health status over the last year • Fifteen of 15 assessments (100%) listed medications and potential side effects relevant to functional status. • Fifteen of 15 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills.	

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		• Fifteen of 15 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). • Fourteen of 15 assessments (93%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. • Thirteen of 15 assessments (87%) included discussion of the individual's potential to develop new functional skills. • Fifteen of 15 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. • Fifteen of 15 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. • Nine of 15 assessments (60%) 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 comprehensive information regarding the monitoring schedule. For example, Individual #463's monitoring section only stated "QIDP/Life Skills" and provided no more information regarding frequency. • Fifteen of 15 assessments (100%) included a re-assessment schedule. • Fifteen of 15 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. • Fifteen of 15 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Fifteen of 15 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. • Fifteen of 15 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement." • Fifteen of 15 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP. All areas were noted to have continued improvement with the exception of the identification of the monitoring schedule. This was identified in the last report as	

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		needing to be improved in order to sustain substantial compliance but as of this review, the needed improvement has not been noted; therefore, this provision did not sustain substantial compliance. Additionally, moving forward, the OT/PT assessment will contain the recommendations for overall effectiveness and compliance monitoring. This was not noted to be in effect at the time of the review and will need to be reviewed at a later date.	
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** For individuals receiving OT/PT supports and services, 15 of 15 plans for Samples P.1 and P.2 (100%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. For 15 of 15 individuals in Samples P.1 and P.2 (100%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Primary integration was in the form of discussion and review of the PNMP. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed resulting in the following findings: • Six of six individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For six of six 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. • For four of six individuals' records (67%) 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 #617, whose goal simply stated to "increase range of motion"; this did not provide the IDT information that would permit it to determine when the goal or objective is met or when lack of progress would indicate a need to revise the intervention. • 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. **Indirect OT/PT Programs** The implementation of these plans is discussed under Section O4 for PNMPs and in	Noncompliance

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		Section S for skill acquisition plans and under Section O.3 for implementation of PNMPs. **<u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u>** An OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Fifteen of 15 ISP annual meetings for Sample P.1 and P.2 (100%) had a member from either OT or PT present to represent the disciplines. Fifteen of 15 ISPs or ISPAs from Samples P.1 and P.2 (100%) integrated the OT/PT interventions. The ISP or ISPA consistently described the supports based on the rationale provided in the therapy assessment. Integration was primarily in the form of PNMP review and acceptance. Skill acquisition programs were now recommended in the OT/PT assessments; therefore, the Monitoring Team was now able to determine if these were integrated into the ISP. Eleven of 15 (73%) were noted to be represented as part of the ISP. This was a noted improvement since the previous review. In order to obtain substantial compliance, DSSLC must continue to improve the inclusion and integration of recommendations included as part of the OT/PT/SLP assessment into functional goals and objectives for the individuals. Six of six 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. Progress included the following indicators: • Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). • Reported the consistency of implementation. • Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. • Described the benefit of the goal to the individual. Although this indicator was not present as part of every notes entry, it was observed as part of the initial as well as discharge/final note and therefore meets the intent of this indicator. • A comprehensive progress note was completed on at least a monthly basis. 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	

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		the template remained a positive step forward and continued to result in improved consistency and comprehensiveness of the progress notes. For individuals with PNMPs or SAPs, for zero of six individuals in Sample P.2 (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from QIDP did not include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. The monthly QIDP note did not contain information regarding the status of the direct interventions provided by OT or PT. In order to move towards substantial compliance, there must be evidence that the direct/indirect services provided by OT/PT is reviewed as part of the QIDP'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. To determine whether the Facility implemented the process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed four individuals identified by DSSLC as being Level 2 priority (Level 2 priority indicated the need for additional training) and reviewed evidence that staff working with these individuals had received all necessary training related to PNM. Upon request for the evidence verifying training, DSSLC provided brief explanations stating that the need for staff supporting these individuals to receive non foundational training was changed and therefore no longer was needed. The Monitoring Team requested evidence of this discussion and/or determination but DSSLC could not provide documentation that substantiated these statements. Instead, DSSLC provided two other individuals who were not requested or on the list of individuals provided by DSSLC as requiring additional training. For these two individuals, there was evidence of	Noncompliance

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		Individual Specific Training.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Monitoring System** The Facility did not implement a system for the adequate monitoring of PNMPs. Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. Compliance was achieved with a score of 80% or higher unless it stated that implementation was not noted then a score of "Noncompliance" was automatic. Monitoring tools included adequate instructions/guidelines. The State Supported Living Center Compliance Monitoring Form had guiding questions regarding what the staff conducting the monitoring should be considering and looking for, and included how training should be provided in the occurrence a deficiency was noted and how the information would be shared at the Incident Review Team (IRT). 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. The new process being developed by HT was for the frequency of monitors to be determined by the OT/PT/SLP and included as part of the OT/PT assessments. This frequency would then be included as part of the IHCP. Per interview, the HT directors stated that all areas which are likely to provoke pnm difficulties would be addressed and represented. Once the frequency was established, the IDT would assign responsibilities and share that information with QA/QI. This process was just initiated so it was unable to be reviewed at this time. In order for this approach to be successful, DSSLC must ensure that all areas and all shifts are monitored and that Individuals who are at an increased risk receive more intensive monitoring. There must also be a process in place that is able to track the expected number of monitors and the timely completion of the monitors. 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: Per CMGMT-34-Occupational-Physical Therapy-Exhibit A-3/3/14, the QA/QI Department calculates Inter-Rater reliability. Calculations that were above 80% would be repeated every six months. Calculations that fall below 80% would be repeated	Noncompliance

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		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. The above process was not implemented due to DSSLC being in the process of revising their monitoring system; therefore, this will need to be reviewed at a later date. The Facility did have a comprehensive OT/PT policy. The policy included the following elements: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identifies the frequency of assessments; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; For zero of 15 individuals (0%), 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	

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		were no longer included as part of the risk based PNMP monitoring (as this process was in a period of transition) but continued partially as part of the preventative checks by the wheelchair clinic. The concern was that while wheelchairs continued to be reviewed, there was no longer a formal process in place that reviewed the use of adaptive equipment. Based on review of 15 individuals, 15 (100%) positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per review of the Wheelchair Repair Log (4/1/14 to 5/30/14), for 942 of 942 incidents in which wheelchairs were 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	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self Assessment, 7/3/2014 2. DSSLC Action Plan (undated) 3. DSSLC Presentation Book for Section N, 7/2014 4. DSSLC Dental Care – Suction Toothbrushing Protocol DS-04; 7/23/2014 5. DSSLC Review of Individual's Oral Health Care in the In-Home Setting Policy, un-numbered, dated 2/25/2014 6. DSSLC Dental Services Quality Assurance Policy DS-25, dated 9/11/2012 7. DSSLC policy for Dental Services IV Sedation DS-24, dated 8/1/2011 8. List of all dental office staff 9. List of continuing education for dental professionals 10. List of all individuals who were not current with necessary dental imaging studies 11. List of all dental emergencies that occurred during the reporting period 12. For Individuals #702, #605, #380, and #554: a. Dental progress notes associated with the dental emergency b. IDT meeting minutes documenting the dental emergency c. Integrated progress notes (IPNs) documenting nursing and medical providers' intervention specific to the dental emergency 13. For Individuals #170, #292, #705, #279, and #715: a. Most recent integrated service plan (ISP) b. Most recent annual dental assessment 14. List of all restorative treatments provided during the review period

	15. List of individuals who had not completed restorative dental treatments 16. For Individuals #590, #617, #752, #282, #7, #616, #367, #401, #250, and #366: a. Most recent annual ISP b. Most recent annual dental assessment c. Dental progress notes indicating restorative treatment 17. QA/QI Council Data Meeting minutes for 6/24/2014 18. List of all individuals who are provided a program to mitigate the need for dental sedation 19. For Individuals #276, #549, #742, #727, #131, #62, #345, #286, #552, and #12: a. Data, summary and ISP for program to help reduce the need for dental sedation 20. Dental schedule for previous and following six month period, from the time of the compliance visit 21. Document indicating that the Facility did not require general (intubation) anesthesia for individuals at the Facility 22. For Individuals #705, #587, #474, #445, and #620: a. All anesthesia records, and associated IPNs for dental services **People Interviewed:** 1. Dr. Paul Nelson, DDS, Dental Director **Meetings Attended/Observations:** 1. None
	Facility Self-Assessment: Following its review of the self-assessment for Section Q, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. The Self-Assessment did not give information other than that the audits met timeframes, sample size requirements, and if compliance was achieved. • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did identify the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was provided, mostly only overall percentage of compliance without information on what did and did not comply. • The Monitoring Team could not determine that the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring. • It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility's self-assessment stated that the Facility was in substantial compliance with Sections Q.1 and Q.2; however, the Monitoring Team determined that the Facility was not in substantial compliance with Sections Q.1 and Q.2.

	Summary of Monitor's Assessment: The Facility continued to maintain a robust dental office, with adequate professional and support staffing. The Facility ensures close monitoring of individuals when provided TIVA services, and ensures that annual dental assessments are completed timely. The Facility has enhanced several policies to better delineate its process for suction toothbrushing and the provision of oral health care at the living area. The Facility's QA/QI department has tracking of missed dental appointments. The Facility ensures prompt restorative treatments. The Facility must, however, better integrate oral health care services with other departments, through the IDT process; enhance its ability to track pending and administered dental services; develop and implement a process to assess the provision of oral health care, including suction toothbrushing by staff, at the living area; and ensure a QA process that assesses potential adverse outcome following oral health care treatments. Because of these outstanding issues, the Facility remains noncompliant with Sections Q.1, and Q.2. The following are some additional comments, and concerns, specific to each Section: Section Q.1: As noted during the last compliance visit, 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, and restorative treatments, are provided at the level of standard of care practice. The Facility also enhanced its policy on suction toothbrushing to reflect the dentist's responsibility in identifying the need for and prescribing suction toothbrushing. The Facility also developed a new policy to address oral health care practices at the living area. The Monitoring Team noted that documentation of dental emergencies was not effective, and there was delay in providing prompt treatment of dental care for dental emergencies. 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. Some examples of the areas that need continued improvement include: The Facility must 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 associate with the provision of oral healthcare. The IRRF, or other components of the ISP, did not clearly delineate all necessary treatments, including frequency of treatments, associated risks, and monitoring parameters when providing oral healthcare supports. Because of the issues listed above, the Monitoring Team determined noncompliance with Section Q.1. Section Q.2: DSSLC provides adequate TIVA resources, and the Facility provides clinical monitoring before, during, and post sedation. Through the Facility's QA/QI process, the Facility had significantly improved its process for tracking and trending missed dental appointments. 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 did not provide evidence of substantially implementing programs to help mitigate the need for restraint during dental treatments. For these reasons, the Facility is not in substantial compliance with Section Q.2.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess the Facility's ability to address 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; use of suction toothbrushing; and dental imaging <u>Dental Administration</u> The Facility maintains the following dental office staff: • One full time dental director, who provides 12 hours of direct care per week • One part time staff dentist, who provides 30 hours of direct care per week • Three part time contract dentists, who collectively provide 35 hours of direct care per week. • One part time contract oral surgeon • Two dental hygienists, who each provided 40 hours of direct care per week • Two dental assistants, who collectively provide a total of 48 hours of direct care per week. • One contract anesthesiologist, who provides approximately ten hours of service to the Facility each week There was no evidence that dental professionals were provided continuing education specific to the field of special needs dentistry. The Dental director informed the Monitoring Team that the DADS dental database had recently been established and is functional at the Facility, and that the Facility had recently started entering data into the system. <u>Restorative Dental Treatments</u> The Monitoring Team requested a list of all restorative treatments completed, and not completed, during the compliance review period, including the dates when restorative treatment was identified as necessary, dates when restorative treatment was scheduled, and reason why restorative treatment was not completed timely. The Facility indicated that a total of ten individuals (Individuals #590, #617, #752, #282, #7, #616, #367, #401, #250, #366) were not current with restorative dental treatments. Following review of the clinical records, the Monitoring Team noted that for eight out of the ten (80%), pending restorative treatments were scheduled to be completed within a reasonable time period of two months, from the initial identification for the need of restorative treatment. Furthermore, of the two pending treatments (Individuals #7 and #250), who were scheduled for restorative treatment longer than two months from the date when the need for restorative treatment was identified, documentation for one (Individual #7) included a clinically rational explanation for the need to postpone	Noncompliance

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		treatment. • Individual #7 was noted on 3/25/2014 to need significant dental treatment, including extractions and restorative treatment, and because of the extensive dental services required, the Individual is not scheduled to complete all treatments until 9/14/2014. • Individuals #250 was noted to require restorative treatment 4/7/2014, and is scheduled to have treatment completed on 9/3/2014, five months after identifying the need for restorative treatment, and the rationale provided for the delay was "first opportunity for completion". Summary: When identifying a need for restorative treatment, the Facility provides restorative treatment without prolonged delay. <u>Dental Emergencies</u> To assess dental emergencies, the Monitoring Team requested 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: • Copy of all associated dental progress notes, associated with the dental emergency • ISP minutes documenting the dental emergency • Integrated Progress Notes (IPNs) associated with the dental emergency • Dental progress notes associated with the dental emergency. There were 17 reported dental emergencies that occurred during the reporting period. The Facility provided four of the five requested examples for review (Individuals #702, #605, #380, and #554). • In zero out of four cases (0%), the dental progress notes in the dental record 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. • In three out of four cases (75%), the IPN reflected the dental note's assessment and treatment of the dental emergency. However, for only one out of four examples (25%) were specific monitoring and reporting parameters and follow-up instructions documented by the dental staff on the IPNs, for living area staff to monitor. • IPNs written by a nurse or medical provider documented the oral health care emergency that was referred to the dental office in zero out of four (0%)	

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		examples. • Because initial triage IPNs by the nurse, which would indicate subjective and objective findings from a nursing assessment of the acute dental emergency, were not provided, the Monitoring Team could not determine if prompt treatment was consistently provided for dental emergencies. Furthermore, per documents provided for Individual #605, the Monitoring Team determined that definitive treatment was not provided timely. • In zero out of five cases (0%), there was evidence to support that the IDT discussed the dental emergency. Summary of some examples identified by the Monitoring Team: • Individual #605: o A nursing IPN was documented on 2/16/2014, indicating "F/U C/C toothache", there was no assessment documented by a physician, and Tylenol was given for pain." A follow-up IPN by the nurse was documented on 2/17/2014, at 2005, that indicated pain level was "4", and Tylenol was given. o A Dental progress note was documented on 2/18/2014, indicating pain, and an apical abscess of tooth #29, and the need to schedule extraction under anesthesia. The dental progress note did not comment on interim treatment, or monitoring and reporting parameters for living area staff and nurses to monitor. o On 2/27/2014, an IPN written by the nurse indicated that staff are to report pain, swelling, and drainage to the nurse, as informed by the dental clinic. o On 2/28/2014, the dental staff documented on the IPN that #9 area was rechecked, and the existing core build up fell off from tooth #9. The dental progress note, documented on 2/28/2014 indicated that sedation would be required to complete treatment. Nurses IPN notes were documented on 2/27/2104, and 2/28/2014, indicated a focused nursing assessment of the oral cavity. Notes did not document any abnormal issue with tooth #9; however, the nurse did document that the Individual had refused follow-up with the dental office on three attempts. o Treatment under sedation was not scheduled until 3/19/2014, and in addition to issues related to tooth #9, three other teeth were noted to need restorative treatment. o The dental office documented a dental progress note on 3/27/2014 indicating that "post op visit healed up on ext sites". This was the first documented follow-up, following the extractions on 3/19/2014.	

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		○ There was no indication that the dental staff documented on the IPNs issues related to the 3/19/2014 extractions, and no indication that living area staff were informed of monitoring and reporting parameters, or follow-up instructions. ○ No nursing IPNs were provided for review that demonstrated follow-up to the extraction on 3/19/2014. • Individual #380: ○ The Facility indicated that there was no evidence of documentation by the nurse regarding triage of a dental emergency; however, the Individual was seen on 6/9/2014 by the dental hygienist because nursing staff requested that dental issues be ruled out, secondary to maladaptive behavior. ○ The dental progress note, dated 6/9/2014, stated "no signs of swelling, no decay seen, no reason dental for his crying or hitting self". There was no indication that the dentist evaluated this individual, and no evidence that dental imaging studies were obtained. In this example, there were monitoring and reporting parameters documented for living area staff to monitor at the living area. ○ An IPN was documented on 6/9/2014 that documented the same statement that was documented on the dental progress note, dated the same day. • Individual #554: ○ A dental progress note and IPN written by the dentist indicated that a dental emergency visit occurred on 1/7/2014, and that "No offending teeth seen. (Individual) will have iv sedation very soon allowing x-rays and complete exam. There was no other documentation provided for review indicating instruction for staff to monitor and report signs and symptoms of possible dental issues, no specific follow-up instructions, and no documentation of the completed assessment under sedation. ○ There was no IPN documentation provided to indicate nursing and living area staff reporting of the potential dental issues, or follow-up. Conclusion: The Monitoring Team noted that dental progress notes did not consistently delineate a complete oral health examination; specific monitoring and reporting parameters and follow-up instructions were not well documented by the dental office staff; there was no evidence of IDT involvement in addressing dental emergency cases, even when there was noted treatment delay because of maladaptive behaviors, and the need for dental extractions. For Individual #554 and #605, it appeared that treatment delay was secondary to lack of prompt availability for sedation; there were no initial triage notes documented on the IPNs by the nurse; and for Individual #605, the nurse assessed and	

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		treated the individual with Tylenol for two days before being assessed by the dentist, without assessment by the living area physician during the interim. This Individual was noted to have a dental abscess. <u>Dental Imaging</u> 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, revised 3/15/2014. The list of all individuals who were not current with their scheduled dental imaging studies indicated that two individuals were not provided regularly scheduled dental imaging studies (individuals #262, and #222). Per the document request, the Monitoring Team requested the following information for the first five and last five individuals on the current name key for this reporting period: • Documentation indicating current dental x-ray status o Clinical documents of dental x-ray (x-ray report) o Date when dental x-rays were completed o Type of x-rays completed • For individuals not current with dental x-rays, copy of IDT, or ISP minutes, documentation commenting on delinquent dental x-rays, and plan to address incomplete dental x-rays. The Monitoring Team was not provided with documentation indicating the current dental x-ray status; however, the Monitoring Team was provided documents indicating that no dental x-rays were obtained or needed during the past six months. For this reason, the Monitoring Team was not able to review clinical records to determine if the individuals were current with scheduled dental imaging studies. The Monitoring Team did note that the current dental policy for dental x-rays was updated and reflected that the Facility was to follow ADA guidelines for dental imaging. Conclusion: The Monitoring Team noted that the current dental policy for dental x-rays was updated and reflected that the Facility was to follow ADA guidelines for dental imaging. Because necessary documents were not provided, the Monitoring Team was unable to determine if Individuals were current with necessary dental imaging studies.	

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		Annual Dental Examinations, Dental Hygiene, and Schedule for Oral Health Care To assess the Facility's ability to provide routine oral healthcare, the Monitoring Team requested a copy of the previous six months, and pending six months, annual dental schedule, and an alpha list of all individuals who had not fully completed their annual dental examination. In addition, the most recent two dental summaries, and associated IPNs, dental hygiene records, and most recent ISP documenting dental issues was requested for the first, and then every fifth, individual on the current name key, for a total of five examples (Individuals #170, #292, #705, #279, and #715). The Facility did not provide a complete copy of the dental office schedule for the future six months dental office visits, as requested. For each of the examples reviewed, the Facility documented that dental IPNs for dental services were not available, and for several examples, a document was provided stating IPNs had been purged. Furthermore, the Monitoring Team could not identify IPNs, for any of the five examples reviewed, documenting oral health care issues, including IPNs for oral hygiene, and following annual oral health examinations. As reported in Provision V1, purged documents are available from the Records Department, so it is unclear why these IPNs could not be provided. Review of the most recent dental progress notes, related IPNs, past two annual dental assessments, ISP, and dental hygiene records, for Individuals #170, #292, #705, #279, and #715 showed: • 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%) examples. • The most recent annual dental summary was completed prior to the annual ISP meeting, in five out of five (100%) examples. • The most recent annual dental assessment evaluated oral hygiene, periodontal disease, and gum health in four out of five (80%) examples. • The most recent annual dental assessment documented the level of restraint required to perform dental examinations and treatments, in five out of five (100%) examples. • The most recent ISP accurately reflected special requirements, such as the use of spin tooth brushes, specific types of toothpaste, mouth rinsing, flossing, special supports, and frequency of oral hygiene in zero out of three examples (0%). ISPs were not provided for Individuals #715,and #170. • The most recent annual ISP documented oral health care issues, in one out of three (33%) examples. ISPs were not provided for Individuals #715 and #170. • The most recent ISP accurately documented clinically significant issues, as	

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		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 three (0%) cases. ISPs were not provided for individuals #715 and #170. • The annual dental assessment documented when the last dental x-rays were obtained, in zero out of five (0%) examples. • The most recent annual dental summary included a comment about oral cancer screening in zero out of five (0%) examples. • Dental hygiene was provided at least once during the previous six months in three out of five examples (60%). The Facility must ensure that the ISP includes a clinically meaningful summary of oral health care issues, including current condition, pending treatments, obstacles to dental treatment, prognosis, risks, and benefits of oral health care treatments, and all necessary supports for oral health care. The Facility must also ensure that oral health care evaluations, and treatments are clearly documented, in language that can be understood by staff who are not dental personnel. <u>Suction Toothbrushing</u> 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 ISP, and the most recent quality assessment of suction toothbrushing. In addition, the Facility's Dental Care – Suction Toothbrushing Protocol DS-04; revised 7/23/2014, was reviewed, and a new policy was developed for oral health care: DSSLC Review of Individual's Oral Health Care in the In-Home Setting policy, dated 2/25/2014. The Facility policy on suction toothbrushing was updated on 7/23/2014, to reflect the dentist's responsibility for assessing the need and for prescribing suction toothbrushing; in addition, the protocol also describes technical details of the dental toothbrushing program. The Monitoring Team was provided a new dental policy, DSSLC Review of Individual's Oral Health Care in the In-Home Setting policy, dated 2/25/2014, which delineates the Facility process to assess efficacy of toothbrushing, and oral health care at the living area. The Facility provided a list that indicated a total of 115 individuals received suction toothbrushing, and the Monitoring Team reviewed the first five individuals on the list (Individuals #170, #633, #279, #292, and #509), and requested the most recent oral health care rating scale; copy of the Integrated Support Plan (ISP), PNMP, and IRRF; and evidence that the individual's application of suction toothbrushing by staff was periodically assessed by a dental professional:	

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		• Zero out of five cases reviewed (0%), included documentation to support that the Facility regularly assessed efficacy of staff's administration of suction toothbrushing. • The Integrated Risk Rating Form (IRRF) indicated the risks associated with suction toothbrushing in zero out of five cases reviewed (0%). • 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%). • Evidence to support specific instruction to direct care and nursing staff, such as the PNMP or other form of communication, on the Individual's special and specific needs associated with suction toothbrushing was not provided. The Facility must continue to enhance its overall process for suction toothbrushing to ensure that the ISP includes a comprehensive overview of the associated risks and benefits of suction toothbrushing; rationale for the use of suction toothbrushing, and specific techniques to overcome challenges; and potential risks associated with the use of suction toothbrushing. Furthermore, direct care staff, and nursing staff must be made well aware of specific instruction on the use of suction toothbrushing, including safety issues, specific techniques to overcome challenges, and potential risks associated with the use of suction toothbrushing. The Facility must ensure that dental professionals periodically assess the staff's provision of suction toothbrushing, and assess for efficacy and safety issues. Conclusion: As noted per the last compliance visit, 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 and restorative treatments, are provided at the level of standard of care practice. The Facility also enhanced its policy on suction toothbrushing to reflect the dentist's responsibility in identifying the need for suction toothbrushing and prescribing suction toothbrushing. The Facility also developed a new policy to address oral health care practices at the living area. The Monitoring Team noted that documentation of dental emergencies was not effective, and there was delay in providing prompt treatment of dental care for dental emergencies. 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. Some examples of the areas that need continued improvement include: The Facility must enhance the annual ISP process to ensure that all oral health related issues, including the	

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		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 should clearly delineate all necessary treatments, including frequency of treatments, associated risks, and monitoring parameters when providing oral healthcare supports. 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; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	To assess compliance issues for Section Q.2, the Monitoring Team reviewed the Facility's processes related to dental QA, programs to help reduce the need for dental related sedation, and issues related to dental anesthesia, and dental scheduling. <u>Programs to Help Minimize Restraint</u> To assess the Facility's ability to better enable least restrictive oral health care treatment, the Monitoring Team requested the following: • Alpha list of all individuals who are provided a process to help minimize the use of sedation for dental services • 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 • 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 a. Copy of program, specific for minimizing dental sedation b. Copy of program data for past six months c. Copy of current ISP or addendum to ISP that documents the use of the program, and expected outcome d. Copy of scheduled opportunities for the program e. Copy of completed opportunities for the program It should be noted that none of the requested sample documents that were provided for review were from the first ten individuals listed on the list of all individuals that were on the alpha list of all individuals who had a dental restraint mitigation program in place. Review of the data, summary of data, graphs and ISP, specific for the program to help reduce the need for dental sedation, for the samples provided by the Facility, albeit not the sample requested by the Monitoring Team (Individuals #276, #549, #742, #727, #131, #62, #345, #286, #552, and #12), indicated the following: • There was documented evidence that a specific program was developed in ten out of ten examples (100%). • Data was collected, as delineated by the program, in one out of ten examples	Noncompliance

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		(10%). • Data was graphically represented in one out of ten examples (10%). • The ISP or addendum to the ISP made reference to the program in ten out of ten examples (100%). • There was evidence that the program was provided at least two times per month in one out of ten examples (10%). This indicates programs were not implemented frequently enough to have a high likelihood of success. Summary: The Monitoring Team was unable to assess the efficacy of the Facility's program to help mitigate the need for dental restraint because the requested samples were not provided, and because data were only graphed and provided for one out of the ten samples that the Facility provided. However, even for the sample provided, the program was provided at least two times per month for only 10%. <u>Dental Schedule</u> The Facility provided a copy of an electronic dental schedule; however, the Monitoring Team was unable to effectively review the schedule because the printout did not list all evaluations and treatment. The dental director indicated by written document that the Facility is working to correct the malfunction causing dental appointments to be cut off from the printouts. The Facility provided a written document indicating that the Facility was unable to schedule future dental appointments on its electronic scheduling system, and did not provide a schedule for future six months scheduled dental appointments. The Facility provided a document that listed missed appointments and copies of the Facility's QA/QI meeting minutes for 6/24/2014. The Facility reported that during the reporting period: • Total missed appointments: 279 • Total scheduled: 1228 • Total attended appointments: 949 • Missed due to illness: 47 • Missed due to staffing issue at the home: 44 • Missed due to staffing issues at the dental office: 20 • Missed due to living area staff forgetting the appointment: 104 • Missed secondary to failed TIVA appointment: 0 • Missed due to not obtaining consent: 0 • Missed due to other issue: 64	

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		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; although significant progress was made through the QA/QI assessment of missed dental appointments, the Facility must be enable to effectively track pending dental appointments. General Anesthesia (intubation) The dental director reported that the Facility has not identified anyone who required general anesthesia through intubation; however, if needed, they would refer the individual to the local hospital for such service. The Monitoring Team compliments the Facility for having a process to provide general anesthesia (intubation) for individuals who may require such resource in the future. Oral Sedation 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. Total Intravenous Anesthesia (TIVA) 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 requested a list of all individuals who required TIVA for their oral healthcare needs, and a list of all individuals who received TIVA during the most recent six months. For the last five individuals on the list, the Monitoring Team requested a copy of TIVA records, and nursing notes associated with post anesthesia monitoring. 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. 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. 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	

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		determined that the Facility consistently utilized standardized clinical assessment forms for TIVA services. The Facility provided a document, Those That Require TIVA, that indicated 90 individuals require dental services under TIVA for all dental services; however, the list of all Individuals who received dental services for the past 12 months with TIVA indicated that 203 individuals were provided dental services with TIVA support. Furthermore, the Facility provided a list of 46 individuals who were currently pending dental services with TIVA. Per Section Q.1, of this report, the Monitoring Team was provided documentation indicating that two individuals were delinquent with dental imaging studies and ten individuals were delinquent with restorative treatment. The Monitoring Team is concerned that the Facility is unable to accurately track individuals, and their oral health care needs and pending services. The Facility provided documentation indicating that a total of 171 TIVA opportunities were provided during the reporting period, averaging 28 TIVA opportunities each month, and that 60 hours of TIVA services are currently available to the Facility each month. Given the noted 203 individuals who required TIVA services during the past 12 months, the Facility requires a minimum of 34 TIVA opportunities per month, just to provide comprehensive annual examinations, necessary dental x-rays, and semiannual dental cleaning. Additional TIVA opportunities are necessary to ensure individuals can get prompt treatment for restorative, and other oral health care services, when clinically necessary. Review of TIVA records for the first five individuals on the list of individuals who require TIVA (Individuals #705, #587, #474, #445, #620) demonstrated: • In five out of five cases (100%), anesthesiology records were complete, and documented all necessary monitoring parameters. • In five out of five cases (100%), there was documentation of necessary monitoring parameters by the infirmary nurse, until the individual reached a REACT score of greater then or equal to eight, on two consecutive occasions. • In five out of five cases (100%), the dental office ensured that serious side effects of the anesthesia provided were communicated to the living area. • In five out of five cases (100%), the nurse performed, and documented pre-sedation assessment. Summary: The Monitoring Team continues to be impressed by the Facility's TIVA program, and for ensuring exceptional post anesthesia monitoring during the procedure and follow-up at the infirmary. The Facility must enhances its ability to more effectively track individuals	

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		and their oral health care needs, and must continue to ensure that all individuals who can safely benefit by TIVA services, are provided TIVA as clinically indicated. <u>Dental Quality Assurance (QA)</u> At the last two compliance reviews, 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 for potential adverse outcome, such as pneumonia, injuries, and maladaptive behaviors, following a dental procedure. The Monitoring Team was provided QA/QI data meeting minutes for 6/24/2014. 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, and also overall data for fractures, injuries, interventions for maladaptive behaviors, and pneumonia; however, there was no specific data, and analysis reflecting a review if such issues possibly occurred secondary to dental treatments. Also, there was no evidence to indicate the QA/QI department or dental department was assessing efficacy of the provision of oral healthcare at the living area, including suction toothbrushing, at the living area. During discussion with the dental director, the Monitoring Team was informed that the Facility had yet to fully develop and implement a formal QA process to monitor for adverse outcomes following dental visits, or to assess the provision of oral health care at the living area, but does do occasional informal assessments, which are not effectively documented. Summary: 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, and to assess the provision of oral health care, including suction toothbrushing, at the living area. Conclusion: The Monitoring Team recognizes that DSSLC provides adequate TIVA resources, and that the Facility provides clinical monitoring before, during, and post sedation. Through the Facility's QA/QI process, the Facility had significantly improved its process for tracking and trending missed dental appointments. The Facility did not adopt a mechanism to efficiently track and trend dental services, or to maintain an effective dental schedule.	

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		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 did not provide evidence of substantially implementing programs to help mitigate the need for restraint during dental treatments. For these reasons, the Facility is not in substantial compliance with Section Q.2.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self Assessment 7/3/2014 2. DSSLC Action Plan (undated) 3. Facility Section R Presentation Book 4. Communication Services Policy (CMGMT-23, rev 10/23/13) 5. Speech Department Handbook rev: June 2014 6. Record Reviews of Individuals: • Sample R.1: Individuals #111, #118, #296, #383, #424, #595, #639, and #788 • Sample R.2: Individuals #199, #222, #247, #433, and #503 • Sample R.3: Individuals #94, #141, #199, and #509 • Sample R.4: Individuals #139, #687, and #746 7. Communication Master Plan 8. List of current SLPs, caseloads and ratios 9. Copies of each SLP's current license and ASHA certification 10. Continuing education and training completed by the SLPs in the past 12 months 11. Facility list of new admissions since the last review 12. Tracking log of SLP assessments completed since the last review 13. Facility list of individuals with severe language deficits 14. Facility list of individuals with PBSPs and replacement behaviors related to communication 15. PBSP minutes and attendance rosters for the past six months 16. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 17. Facility AAC screening forms 18. Facility AAC-related database reports/spreadsheets 19. Facility list of general common area AAC devices 20. Facility list of individuals receiving direct communication-related intervention plans **People Interviewed:** 1. Becky Nurre CCC-SLP Director of Communication Services 2. Paula Horn PT Director of Habilitation Services 3. Six DCPs (Timberhill, Cedar Falls, and Westridge) **Meeting Attended/Observations:** 1. Mealtimes and Transitions- Garden Ridge, Cedar Falls, Houston Park and Westridge
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 7/3/14 and Action Plan undated. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement,

	the Facility found it was in compliance with Provision R.1 and R.2 and not in compliance with R.3 and R.4. This was consistent with the Monitoring Team's findings. For Section R in conducting its self-assessment: The self-assessment continued to be nicely detailed. 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 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: 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. Presence in the ISP of how the individual communicates and how staff can bridge communication was much improved but integration into SAPs remained inconsistent. **Provision R.1:** This provision was determined to be in substantial compliance. DSSLC was at full capacity with regards to Speech Pathologists. 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. **Provision R.2:** This provision was determined to be in substantial compliance. Individuals identified as having decreased communication were provided with comprehensive assessments or screenings that would identify the need for further assessment. 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. **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 and statements regarding how staff can better bridge any gaps in communication. Concerns were noted however regarding AAC being readily available and utilized within the home environment. Additionally, a monitoring process was not implemented that will ensure all devices are working properly, are available, and staff are provided consistent modeling on how to use the devices. **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, and implementation of the device. DSSLC had developed a system that had the needed guidelines but the process was still in the implementation stages 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: Sample R.1: Consisted of 8 Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Consisted of five Individuals receiving direct speech services. Sample R.3: Consisted of four Individuals with a PBSP and communication deficits. Sample R.4: Consisted of four Individuals from Sample R.1 above with AAC systems **Staffing** The Facility did provide an adequate number of speech language pathologists or other professionals, such as assistive technology (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. As of this review, DSSLC was fully staffed with the director, six staff SLPs (five who have one unit each and one who has most of the direct speech therapy treatments) and one Speech Pathology Assistant (SPA). The SPA was to help provide modeling as well as assist in the development of plans and programs, provide direct speech therapy treatments, and assist with the monitoring process. 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 treatment, and completing monitoring of indirect communication services/supports. **Qualifications:** Seven of seven positions for SLPs (100%) for which documents were provided to the Monitoring Team were filled by licensed SLPs. • Seven of seven SLPs (100%) were licensed to practice in the state of Texas. • Seven of seven SLPs (100%) had evidence of ASHA certification. **Continuing Education:**	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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: • Dementia Management : Advanced Skills for the Health Care Practitioner • Introduction to Ethical Decision Making in Speech-Language Pathology **Facility Policy** 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. DSSLC had a localized Communication Services Policy (CMGMT-23, rev 10/23/13). The policy contained the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Timelines for completion of new admission assessments • Criteria for providing an update • Outlines assessment schedule. • Frequency of assessments/updates. • Addressing a process for effectiveness monitoring by the SLP. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication • Methods of tracking progress and documentation standards related to intervention plans.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or	This provision was found to be in substantial compliance. Individuals identified as having decreased communication were provided with comprehensive assessments or screenings that would identify the need for further assessment. 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. **Assessment Plan:** The Facility had a reasonable plan to screen/assess all individuals and, based on priority	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>interventions.</td><td>need, assess individuals who would benefit from the use of alternative or augmentative communication systems.

During the last compliance review, DSSLC provided comprehensive assessments to all individuals during admission. Per interview with the Director of Communication Services, this practice has changed and individuals who were admitted only received a screening by the SLP which would assist the therapist in determining if a more comprehensive assessment was needed. The screening document was reviewed and was felt to be comprehensive enough to identify and direct the need for more comprehensive assessment.

The Facility did define the timeframe for the completion of communication assessments/screenings 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:

<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>
<tr><td>4</td><td>Individuals with a Care Code for Speech of 3 or 4 who do not have a PBSP</td><td>12/31/2014</td></tr>
<tr><td>5</td><td>Individuals with a Care Code for Speech of 1 or 2</td><td>12/31/2015</td></tr>
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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)
    - 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:

- 100% of priority 1 Assessments completed
- 100% of priority 2 Assessments completed
- 100% of priority 3 Assessments completed
- 75% of priority 4 Assessments completed
- 75% of priority 5 Assessments completed

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

Assessments Provided

Eight of eight 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.

Seventeen of 17 individuals (100%) admitted since the last review received a communication screening or assessment within 30 days of admission or readmission and five business days prior to the ISP.

For 8 of 8 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP.

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		Thirteen of 13 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. **<u>Communication Assessment:</u>** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Thirteen of 13 individuals' Communication assessments (100%) were signed and dated by the clinician upon completion of the written report; • Thirteen of 13 individuals' Communication assessments (100%) were dated as completed at least 10 working days prior to the annual ISP; • Thirteen of 13 individuals' Communication assessments (100%) included diagnoses and relevance of impact on communication; • Thirteen of 13 individuals' Communication assessments (100%) included individual preferences, strengths, and needs • Thirteen of 13 individuals' Communication assessments (100%) included medical history and relevance to communication • Eleven of 13 individuals' Communication assessments (85%) listed medications and discussed side effects relevant to communication. • Twelve of 13 individuals' Communication assessments (92%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Thirteen of 13 individuals' Communication assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Thirteen of 13 individuals' Communication assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Thirteen of 13 individuals' Communication assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; • Twelve of 13 individuals' Communication assessments (92%) included discussion of the expansion of the individuals' current abilities. • Thirteen of 13 individuals' Communication assessments (100%) provided a discussion of the individuals' potential to develop new communication skills; • Thirteen of 13 individuals' Communication assessments (100%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification; and rationale as to whether or not the individual would benefit from AAC or EC.	

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		• Eleven of 13 individuals' Communication assessments (85%) offered a comparative analysis of health and functional status from the previous year. • Twelve of 13 individuals' Communication assessments (92%) gave a comparative analysis of current communication function with previous assessments. • Eleven of 13 individuals' Communication assessments (86%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • Eight of 13 individuals' Communication assessment (62%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; It should be noted that all assessments, 100% or eight of eight, completed after October 2013 contained this component and all 13 of 13 PNMPs (100%) contained information regarding communication. • Thirteen of 13 individuals' Communication assessments (100%) had a reassessment schedule; • Thirteen of the 13 individuals' Communication assessments (100%) 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; therefore, this was considered appropriate in meeting this component. • Ten of 13 individuals' Communication assessments (77%) 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. • Thirteen of 13 individuals' Communication assessments (100%) made a recommendation about the appropriateness for community transition. • Nine of 13 individuals' Communication assessments (69%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. It should be noted that eight of eight assessments (100%) completed after October 2013 contained this component. **<u>SLP and Psychology Collaboration:</u>** Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs), the following was noted: • Four of four communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. • For four of four individuals (100%) communication strategies identified in the assessment were included in the PBSP.	

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		• For four of four individuals (100%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets for the eight individuals in Sample R.3, participation by a SLP was noted in four of four (100%) meetings. 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. Per the Director of Communication Services, PBSPs are not approved unless the following indicators are present. • There is evidence of collaboration between behavioral services and the SLP regarding PBSPs that have communication as a significant component of the PBSP. • There is collaboration between behavioral services and SLP in developing a skill acquisition plan (SAP). • 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. • Behavioral services staff and the SLP have a plan for regular monitoring of the program established as part of the PBSP.	
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** Based on review of the ISPs for individuals in Samples R.1 and R.2 the following was noted: • In 11 of 13 ISPs reviewed (85%) 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. • Thirteen of 13 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. • Communication Dictionaries for 13 of 13 individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • 13 of 13 ISPs reviewed (100%) included how communication interventions	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. • Eleven of 13 ISPs reviewed (85%) contained skill acquisition programs or clear strategies to promote functional communication. • Eleven of 13 ISPs reviewed (85%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** For two of two individuals in Sample R.1 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days. Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following: • Two of four observations (50%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for one of four individuals (25%) were noted to be in use in each observed setting. • AAC systems for three of four individuals (75%) were portable. • AAC systems for four of four individuals (100%) were functional. • For one of four individuals (25%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices:** Observations were completed in four homes and to determine the presence and use of general AAC devices. Findings included the following: • Four of four homes (100%) had general use AAC devices present in the common areas. • Twelve of 14 (86%) general use AAC devices were operational. • Sixteen of the sixteen general use AAC devices (100%) noted contained clear directives on how staff should use these devices. • Ten of 16 general use AAC devices (63%) noted had a clear function within that setting/situation. Single button devices to request drinks or meals were noted at the side of the door rather than at tableside. In the current location, individuals would need to cross the room in order to make the request. Many times, these individuals used wheelchairs and were unable to self propel. • Zero of sixteen general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been	

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		appropriate (for example: mealtimes, washing hands, music) but were not prompted by staff or utilized by the individuals. **Direct Communication Interventions** Review of the individuals' records from Sample R.2 showed the following: • Five of five individual's direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For five of five individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For five of five individuals (100%), information was present regarding whether the individual showed progress with the stated goal. • For zero of five individuals (0%), a description was found of the benefit of the device and/or goal to the individual. There was no evidence that the therapist reported 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. • For five of five individuals (100%), a report was found regarding the consistency of implementation. • For five of five individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • 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. . • For five of five individuals (100%) progress notes occurred at a minimum monthly. **Indirect Communication Supports:** Programs for individuals in Sample R.1 who received indirect communication supports were reviewed and found: • Three of three individuals' indirect plans (100%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For three of three individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale.	

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		For four of four individuals in Sample R.4 (100%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. Zero of three individuals (0%) receiving indirect Speech Services (Sample R.1) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for one of three individuals (33%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. Review consisted of only stating that the service was provided, a general observation and offered minimal information regarding effectiveness of supports in meeting desired outcomes. • Quarterly documentation for zero of three individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of three individuals (0%) identified consistency of implementation. • Quarterly documentation for one of three individuals (33%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. **Staff Interviews** Four of six staff interviewed (67%) were knowledgeable of the individual and their communication related programs; direct support professionals had difficulty with the following questions • Stating whether the individual had an AAC system. • Whether there was a communication program. • Describing the communication program goal. • Described the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. **Competency-Based Training and Performance Check-offs:** Based on review of the NEO training curriculum, and individualized training, DSSLC did develop comprehensive competency based training regarding communication services. • The training materials reviewed did address all the appropriate content areas listed below: o Methods to enhance communication o Implementation of programs o Benefits and use of AAC o Identification of non-verbal means of communication.	

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		Three hundred and seventy six of 376 new employees between 12/1/14 and 6/30/14 (100%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. Weekly monitoring sheets were reviewed but were noted to be completed on an inconsistent basis with at times with monitors not being completed for multiple weeks. 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. **Individual-Specific Competency-Based Training** To determine whether the Facility had a process to determine whether staff had been trained on individuals' communication devices, the Monitoring Team reviewed evidence that all assigned staff for six individuals in Sample R.1 and R.2 had received training related to Communication SAPs and/or program. Four of six (67%) individuals' assigned staff had completed competency check-offs regarding the individuals' communication programs. DSSLC was unable to provide evidence of any training for staff supporting Individuals #296 and #503. 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.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The	**Policy and Procedure** 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. The process was as follows: • 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. • Schedule for shared equipment: Speech Department will monitor monthly and Unit and Programming would monitor weekly. • Schedule for Individual equipment: Speech Department will monitor periodically	Noncompliance

#	Provision	Assessment of Status	Compliance
	communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	and Unit and Programming would monitor weekly. • All information would be entered in to the Speech Data Base. 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. An improvement noted was that guidelines/procedures had been developed that formalized all monitoring processes. 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. Additionally, the occurrence of effectiveness monitoring on a quarterly basis did not appear to be occurring regularly. For example, Individuals #296, #639, and #788 were not provided with effectiveness monitoring although they had communication related SAPs. **<u>Monitoring of Implementation of Communication Supports</u>** Compliance Monitoring forms for implementation of communication supports the last six months for three individuals from Sample R.1 with SAPs were reviewed and the following was found: • For three of three 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. • For zero of three individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. 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. Four of eight individuals from Sample R.1 (50%) 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 lacking detail regarding if the individual achieved progress and if the supports remained appropriate This represented an improvement of 3% since the previous review.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DSSLC Self-Assessment (7/3/2014) 2. DSSLC Action Plan (Undated) 3. DSSLC Presentation Book for Section S 7/25/2013) 4. Documents that were used as part of the document review process included the following. **a.** For S.1, ISPs, related assessments, and SAPs were reviewed for Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765. b. For S.1, the content and composition of SAPs were reviewed for Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765. **c.** For S.2, related assessments, and SAPs were reviewed for Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765. d. For S.3.a, SAPs and data collection forms were reviewed for Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. e. For S.3.b, Facility summary data for community outings and SAP training sessions were reviewed. **People Interviewed:** 1. Trent Lewis – Vocational Services Director 2. Pung Nelson – Director of Life Skills Program 3. Trenton Berrie, MS, BCBA – Interim Director of Behavior Services 4. Laura Dittlinger-Harper, BCBA - Consultant 5. Approximately 25 direct support professionals in the following residences: #522D, #522B, #523B, #523D, #525C, #525A, #525B, #526A, #526D, #508A, #508C, #527A, #527D, and #505B **Meeting Attended/Observations:** 1. Observations were conducted in the following residences: #522D, #522B, #523B, #523D, #525C, #525A, #525B, #526A, #526D, #508A, #508C, #527A, #527D, and #505B
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section S, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the

	SAP/SLP (Communication) Audit, the Program Observation Drill, the Timeliness of Assessment Audit, the Assessment Review, and the Skill Acquisition Program Monthly Review. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations of staff performance, monthly and quarterly review of assessments and SAPs, review by multiple disciplines, such as QA and the Section S BCBA. 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. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources, such as the tracking database for the timeliness of assessment reports. ▪ The Facility often, but not always, presented data in a meaningful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o 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 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. 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 primarily Complete or In Process. ▪ The Facility data identified areas of need/improvement. The Action Plans consistently cited evidence to support the Action Steps, but did not frequently provide additional data or analysis. ▪ The actions did/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: Observations, interviews, and record reviews were conducted on-site at DSSLC from 7/21/2014 through 7/25/2014. 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 attempted to improve the quality of services addressed by Section S of the Settlement Agreement. In the majority of areas, however, no substantive progress was noted and at times, the Facility had regressed. Although several areas continued to lack substantial compliance, there were some areas where progress had been achieved. • Skill Acquisition Programs reflected somewhat greater individualization in the development process. • Skill acquisition programs were somewhat more likely to include appropriate discriminative stimuli, specific instructions, and specific consequences for correct responses. • Substantial improvement was noted in the inclusion of maintenance and generalization strategies in skill acquisition programs. • Skill acquisition programs were likely to include strategies that were practical to implement. Despite the areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • Less than half of the skill acquisition programs were based upon adaptive skill assessments, fewer than a third reflected needs identified in the ISP, and none were based upon a task analysis. In several instances, various assessments for the same individual were contradictory. • Skill training continued to lack the frequency of training trials necessary to develop and strengthen new skills. • The number of individuals provided functional engagement remained essentially unchanged while the percentage of locations with at least 50% functional engagement had dropped for the second consecutive site visit. • Skill acquisition data were incomplete or included documentation errors for two-thirds of the individuals reviewed. • The majority of skill acquisition programs were not implemented consistently or correctly. Based upon interviews, observations, record reviews, and other material, it was evident that the Facility had only limited progress. This information did not support finding the Facility in substantial compliance with Section S of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the	Historical Perspective During the initial March 2010 baseline site visit, it was noted that none of the 10 individuals included in	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>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. In January 2014, although skill acquisition programs reflected some improvement, there was little evidence to suggest that Assessments were more integrated into the skill development program process.

<u>Current Site Visit</u>
During the current site visit, the Facility provided one recent ISP with associated SAPs for 10 individuals. From these, the second SAP presented in the submitted documents for each ISP was selected as the sample. This allowed for a sample of 10 SAPs. The individuals for whom SAPs were reviewed included Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765.

<u>Use of Assessment Information in Planning Skill Acquisition</u>
Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.

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.

<table>
<tr><th></th><th>3/2010</th><th>1/2014</th><th>7/2014</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>29%</td><td>30%</td></tr>
<tr><td>Adaptive skill or habilitative assessment</td><td>0%</td><td>36%</td><td>40%</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>29%</td><td>40%</td></tr>
<tr><td>Skill acquisition plans are related to the individual's preferences.</td><td>0%</td><td>21%</td><td>20%</td></tr>
</table>

Based upon the information submitted by the Facility, it was not evident that assessments were consistently used in the development of SAPs for the majority of individuals living at the Facility. Furthermore, there was no indication of substantive improvement in the use of assessments in comparison with the previous site visit.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• ISPs for only three of 10 SAPs (30%) reflected evidence to support the reviewed SAP. • Functional Skill Assessments (FSAs) for only four of 10 SAPs (40%) 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 60% of the reviewed SAPs, however, it was not evident that the FSA had been effectively used in the development of skill acquisition programs. • As noted in Provision R.2 of this report, 10 of 13 individuals' Communication assessments (77%) 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. The development of SAPs requires a comprehensive and precise understanding of numerous facets of an individual's abilities and limitations. The FSA alone lacks the ability to provide such assessment and understanding. The FSA, however, could serve as the initial component to a more comprehensive assessment, helping to focus attention upon general skill areas in which the individual experienced limitations. It would then be necessary to supplement the FSA with assessments specific to the areas where skill deficits were suggested. This approach could lead to a more comprehensive understanding of the individual and lead to specific and individualized training. Of the 10 individuals included in the sample, only three (30%) 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 10 records (0%) was there indication that the formal assessment of adaptive skills was used in formulating teaching programs. 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. Based upon the available information, there was little to indicate that the Facility systematically and comprehensively integrated assessments into the development of Skill Acquisition Programs. <u>Teaching New Skills</u>	

#	Provision	Assessment of Status	Compliance
		In order to assess the components of the SAPs, a total of 10 skill acquisition programs were reviewed. This sample was comprised of the 10 SAPs presented above for Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765.	

	3/2010	1/2014	7/2014
Plan reflects development based upon a task analysis	0%	0% (33%)*	0% (0%)*
Behavioral objective(s)	0%	42%	0%
Operational definitions of target behavior	0%	67%	60%
Description of teaching conditions	0%	46%	20%
Schedule of implementation plans for sufficient trials for learning to occur	0%	8%	0%
Relevant discriminative stimuli	0%	67%	90%
Specific instructions	0%	58%	70%
Opportunity for the target behavior to occur	0%	83%	70%
Specific consequences for correct response	100%	79%	90%
Specific consequences for incorrect response	0%	83%	80%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	17%	100%
Documentation methodology	0%	75%	100%

* *The number in parentheses reflects the percentage of reviewed SAPs not requiring a task analysis.*

Based upon the information gained in the review, the Facility achieved progress in five of 12 areas (42%), remained unchanged in one of 12 areas (8%), and regressed in six of 12 areas (50%). The Facility was fully successful in two elements (17%).

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

Task analysis

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

All reviewed SAPs did include steps that were labeled as a task analysis. There was no indication, however, that a formal assessment process had been used to identify or select the appropriate steps for each individual. Furthermore, in the materials submitted by the Facility, the section allotted to task analysis materials contained a single page upon which was written, "This facility does not conduct Task

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		Analyses." As a result, there was no evidence to support that these 10 SAPs had been based upon a task analysis. Behavioral objectives None of the 10 reviewed SAPs (0%) 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 reviewed SAPs, nine (90%) included excessively long periods during which training could continue, typically at least three months. Of the one remaining SAP (Individual #765, 10%), the time frame was appropriate, consisting of eight of 10 trials. The behavior identified in the objective (will be able to write his first name), however, did not match the behavior being taught (Sign in at work upon arrival). Operational definitions Six of the 10 reviewed SAPs (60%; Individuals #333, #459, #475, #542, #671, and #765) 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. Examples of SAPs that did not reflect adequate definitions included the following. • For Individual #673, the individual was to write each letter of her name. The only criterion provided in the operational definition was that each letter was to be legible. As legibility is subjective and open to interpretation, the provided definition was likely to result in errors in data recording and the determination of skill acquisition. • For Individual #507, the individual was to indicate a preferred object. Indication of a preference included touching, taking, or not interacting with the object. Such a broad definition was likely to result in confusion about a successful response and allowed for the potential inadvertent reinforcement of undesired or unintended behaviors. Further, "not interacting" with an object would not indicate the object is a preference. There was no indication elsewhere in the assessment or SAP that the individual pushed away objects that were not preferred, so "not interacting" (as in "not pushing away") would not be a useful measure of preference. Description of teaching conditions Two of the 10 reviewed SAPs (20%; Individuals #333 and #673) reflected an adequate description of teaching conditions. For a 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. For the remaining eight SAPs, no description of teaching conditions was provided.	

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		Sufficient trials None of the 10 reviewed SAPs (0%) 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. Specific instructions 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. Seven of the 10 SAPs (70%) included adequate instructions for staff. Opportunity for the target behavior to occur Seven of the 10 reviewed SAPs (70%) reflected the opportunity for the target skill to be performed. (The three SAPs that lacked this involved Individuals #333, #507, and #612). This was a 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 to 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 does 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. Documentation methodology Ten of the 10 reviewed SAPs (100%) 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	

#	Provision	Assessment of Status	Compliance
		achieved. To assess whether the documentation methodologies were sufficient to produce adequate data collection, SAP data collection forms for the previous three months were reviewed for each SAP in the sample. For only three of the 10 SAPs (30%) were data collection forms available for all three months. Of the 21 available data forms, 13 (62%) reflected incorrectly recorded data and 14 (67%) had missing data. As a result, even though instructions appeared to be adequate, the majority of data forms reflected substantial errors. <u>Promotion of growth, development, and independence</u> Despite some noted improvement, due to the limitations presented above, none of the 10 reviewed SAPs (0%) was likely to promote growth, development and independence. <u>Engagement, activities, and informal skill acquisition training</u> 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. 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.	

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
522D	2	4	2	50%
522B	4	7	2	29%
523B	3	4	1	25%
523D	3	6	4	67%
525C	0	2	0	0%
525A	2	6	1	17%
525B	1	1	0	0%
526A	1	5	1	20%
526D	1	3	0	0%
508A	3	5	4	80%
508C	4	7	3	43%
527A	1	6	3	50%
527D	3	5	5	100%

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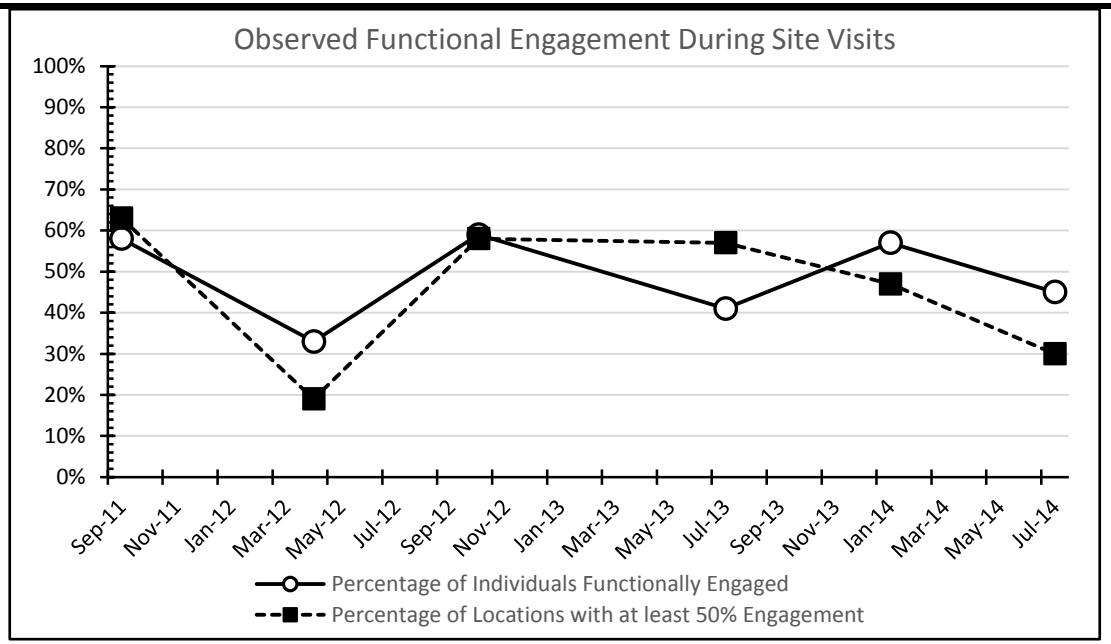
505B	1	3	3	100%
Total percentage of individuals functionally engaged				45%
Percentage of locations with 50% or greater functional engagement				30%

Observations revealed that across all settings 45% of observed individuals were functionally engaged. Furthermore, slightly less than one-third (30%) of all environments observed reflected at least 50% engagement. Circumstances where engagement was lacking during observations included the following.

- In residence 523B, one individual was sitting upon the floor in the hallway. One DSP was holding the individual's arm while using verbal and physical prompts to encourage the individual to stand. When the individual pulled his arm free from the grasp of the DSP, the DSP stood abruptly and walked away and said abruptly, "Fine, sit on the floor."
- In residence 525A, six individuals and two DSPs were present. One DSP was writing in the documentation book. The second DSP was talking to one individual. The remaining five individuals sat for approximately five minutes with no interaction and no materials.

Not all observations conducted at the Facility reflected low levels of functional engagement. In a few settings, staff attempted to provide the materials and attention necessary to maintain reasonable levels of functional engagement.

- In residence 527D, three DSPs and five individuals were present. One individual introduced herself to the Monitor as part of the implementation of an SAP. The remaining two DSPs floated amongst the remaining individuals, offering frequent prompts, encouragement and praise in relation to dining preparation.
- In residence 508A, three DSPs and five individuals were present. Four of the five individuals were provided engagement in the form of conversation, interaction involving training materials, or dining preparation.

#	Provision	Assessment of Status	Compliance
		 Based upon information obtained from the Facility, as well as observations and document reviews, it was reflected that the Facility had not increased previous observed levels of functional 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 in leisure activities.	<u>Historical Perspective</u> During the baseline site visit in March 2010, a review of the records for 10 individuals revealed that formal assessment of skills, needs, and abilities was lacking at DSSLC. In general, attempts by the Facility to assess individual strengths, limitations, barriers, and preferences typically involved anecdotal statements, narrative reports, and generic rating scales. 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. During the July 2013 site visit, documentation indicated that substantial limitations continued concerning the content of assessments, the use of assessments in developing SAPs, and insuring that assessments were submitted in a timely manner. In January 2014, it was noted that although the Facility had improved the percentage of assessments that	Noncompliance

#	Provision	Assessment of Status	Compliance
		were submitted on time, the percentage of assessments not submitted on time remained unnecessarily high. <u>Current Site Visit</u> During the current site visit, the Facility provided one recent ISP with associated assessments for 10 individuals. The individuals comprising this sample of 10 SAPs included Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765. For each ISP, it was expected that the following assessments were provided: Communication, Functional Skills, Integrated Risk Rating Form, Medical, Nursing, Occupational/Physical Therapy, Preferences and Strengths Inventory, Psychiatric, Psychological, Rights, Self-Administration of Medication, Structural Functional Assessment, Task Analysis, and Vocational. For each of the ten ISPs, all assessments except for the Task Analysis were provided. Specific issues related to psychological assessments are presented in Section K of this report. Assessment problems in addition to psychological and behavior assessment were also noted. • No Task Analyses had been conducted for any individual. • A preference assessment using the Preferences and Strengths Inventory (PSI) had been provided for each individual. As the PSI is a subjective tool, it was not clear that the Facility had obtained a valid and reliable measure of individual preferences. Furthermore, it was not evident that that accommodation had been made for individuals' communication limitations. • Although a Functional Skills Assessment (FSA) had been provided for each individual, several weaknesses were noted in the completion and use of the FSA. For example, some FSAs included sections that were not completed. In other cases, the findings of the FSA were contradicted by other data sources, but no attempt to reconcile the findings was documented. 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. Based upon this information, it was not possible to identify any areas of substantial progress in skill or preference assessment at the Facility.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop,		

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

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, 10 SAPs and the latest three data recording forms for each as provided by the Facility were reviewed. The 10 individuals included in the sample were Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765.

The table below reflects the results of the review.

<table>
<tr><th>Element</th><th>Percent Correct</th></tr>
<tr><td>Data recording forms available</td><td>70%</td></tr>
<tr><td>Individual information is correct</td><td>100%</td></tr>
<tr><td>Data current</td><td>33%</td></tr>
<tr><td>Plan is implemented according to the specified schedule.</td><td>33%</td></tr>
<tr><td>Data recorded correctly</td><td>38%</td></tr>
</table>

Specific issues noted included the following.
• Nine of 30 data sheets (30%) were missing
• Fourteen of 21 data sheets (67%) were missing data for at least one trial.
• Thirteen of 21 data sheets (62%) reflected data recording errors, such as recording data on the wrong step(s) or using data symbols not included in the SAP instructions.

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</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>SAPs at the Facility, the 10 ISPs and SAPs in the sample for Provision S.1 (Individuals #91, #333, #673, #459, #475, #507, #542, #612, #671, and #765) were rated on five questions. Those questions and the ratings are presented below.

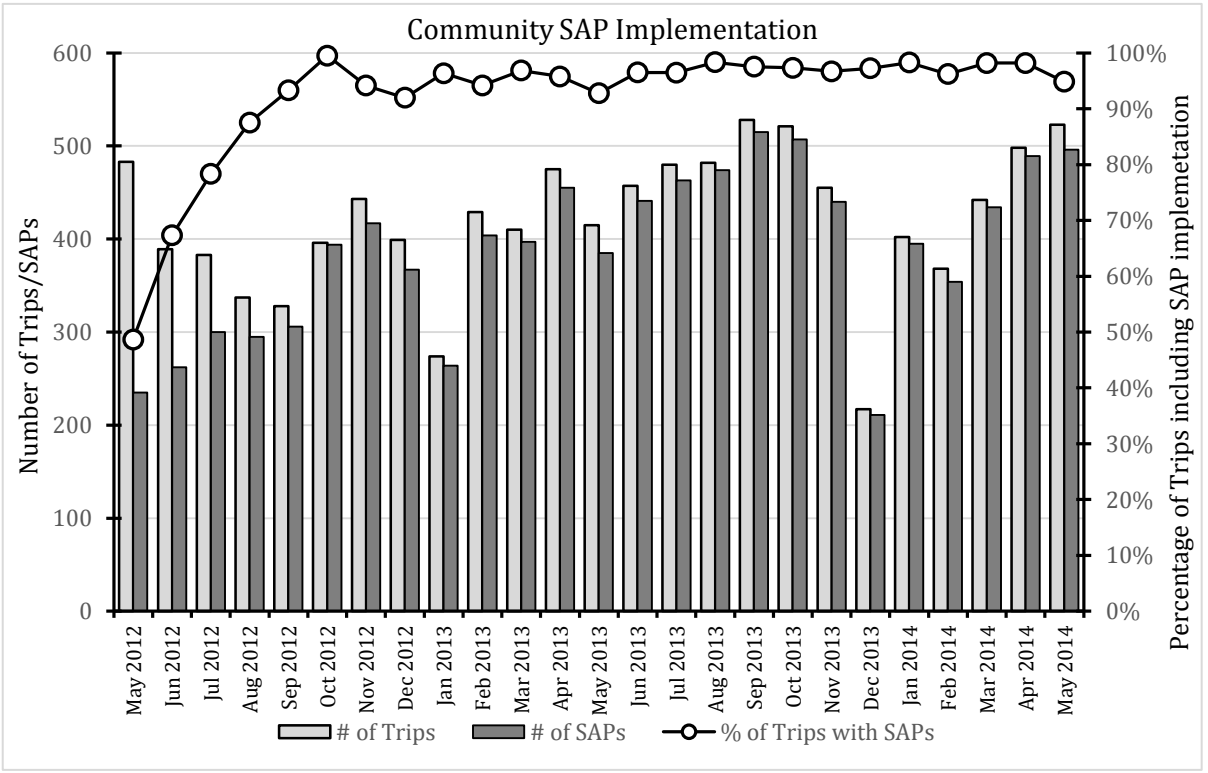
<table>
<tr><th>Practical</th><th>Percentage of SAPs</th></tr>
<tr><td>SAP does not require excessive resources, time or staff</td><td>100%</td></tr>
<tr><td>SAP is not excessively difficult or technical</td><td>90%</td></tr>
<tr><td>SAP can be implemented in relevant environments</td><td>90%</td></tr>
<tr><td>Functional</td><td></td></tr>
<tr><td>SAP addresses specific needs from formal assessment</td><td>40%</td></tr>
<tr><td>SAP targets skills useful for the individual</td><td>50%</td></tr>
</table>

Specific issues noted functionality included the following.
• Only four of the 10 sampled SAPs (40%) addressed specific needs reflected in formal assessments.
• Five of the 10 sampled SAPs (50%) targeted skills that would likely be useful for the individual.

An example in which a SAP was not functional is presented below.
• For Individual #333, the SAP stated that the individual enjoyed washing clothing items. The majority of trials, however, involved refusal by the individual to participate in the task. In addition, when the individual did participate in the training, full independence was documented. This suggested that claims about preferences were incorrect and that the circumstances potentially involved a lack of motivation or interest rather than skill. Therefore, it appeared that the SAP neither targeted skills important to the individual nor was based upon adequate assessments.

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.

Based upon information presented by the Facility, it was noted that some 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.</td><td></td></tr>
<tr><td></td><td>(b) Include to the degree</td><td><u>Historical Perspective</u>
At the time of the March 2011 site visit, DSSLC had generally increased the total number of community</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	practicable training opportunities in community settings.	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, as well as January 2014, reflected a continuation of high numbers of community outings involving SAP implementation. <u>Current Site Visit</u> The table below reflects information provided by DSSLC regarding community outings and community SAP implementation.  This information suggested that, following decreased outings due to inclement weather in late 2013, the	

#	Provision	Assessment of Status	Compliance
		Facility had again increased both outings and community implementation of SAPs. There were concerns, however, about the accuracy of the reported data. For four of the five months reported as part of the current site visit (January, February, March, and May) different documents provided by the Facility reflected substantially different numbers concerning the number of outings. For example, the Presentation Book submitted by the Facility reflected 402 outings in January 2014 with 395 of those outings involving SAP implementation. This suggested that 98% of outings involved SAP implementation. In a separate document, reporting community outing data submitted by the Facility, however, a total of 439 outings were reported for January 2014. This would reduce the percentage of outings involving training to 90%. Although percentages remained high using either dataset, such errors introduce questions about the overall quality of the data. In other words, it is not clear whether either dataset is correct. As a result, no conclusions can be reached regarding community outings or the prevalence of SAP implementation in the community. In order to assess the implementation of SAPs in the community, the Facility was asked to provide all community SAP data collection forms from the past three months for 10 individuals, including Individuals #91, #333, #459, #475, #507, #542, #612, #671, #673, and #765. A total of 42 data collection forms were provided for the 10 individuals. Based upon the forms submitted, there was not a pattern as to the community implementation of SAPs. One individual had only one instance of a SAP implemented in the community in three months (Individual #765), while other individuals were provided as many as nine instances of community SAP implementation in the same time period (Individuals #507 and #671). It was also noted that specific guidelines for community SAP training were inadequate. None of the 42 submitted SAP data collection forms (0%) included any instructions specific to community implementation. For example, Individual #459 was provided a SAP for adding the cost of two or more items using a calculator. The SAP did not provide any instructions regarding training locations, targets, environmental configurations, or calculator requirements. Without such guidelines, it was unlikely that the reviewed SAPs could be implemented consistently or correctly. Concerns about correct SAP implementation were supported by weaknesses noted in the quality of implementation data. Of the 42 data collection forms, 18 (43%) reflected at least one data entry error such as recording data for the wrong step of the program. Two of the 42 data forms (5%) did not include any data, although a session date and trainer initials were provided. Seven of the 42 data forms (17%) did not include the training date. Based upon the noted issues, it was suggested that a substantial number of SAPs were not implemented and documented correctly and as frequently as necessary in the community.	

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Documents Reviewed: 1. Denton State Supported Living Center (DSSLC) Self-Assessment, updated: 07/03/2014 2. Denton State Supported Living Center Action Plans, CV8 undated 3. Denton State Supported Living Center Provision Action Information, updated: 07/02/2014 4. Denton State Supported Living Center Report for Monitors, dated July 21, 2014 for Compliance Visit 8 5. Section T Presentation Book materials 6. DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013 7. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 8. DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, revised 06/01/2014 9. DSSLC Policy CMGMT 39.a: Exhibit I: Pre-Placement Medical Chart QA Protocol, dated 3/20/13 10. DSSLC Policy CMGMT 39.a: Exhibit J: Pre-Placement Doctor to Doctor Contact Protocol, dated 3/20/13 11. DSSLC Policy CMGMT 39.a: Exhibit K: Increasing Individual's Participation at Their Own ISP Meeting, dated 5/17/13 12. DSSLC Policy CMGMT 39.a: Attachment B: Education About Community Placements 13. DSSLC Policy CMGMT 39.a: Attachment L: Plan to Support People to Live in the Most Integrated Setting 14. DSSLC Policy CMGMT 39.a: Attachment N: Process for Reviewing Obstacles to Transition within 180 Days 15. DSSLC Policy CMGMT 39.a: Attachment 0: IDT Review of Post-Move Monitoring 16. DSSLC Policy CMGMT 39.a: Attachment P: Day of Transition Checklist 17. DSSLC Policy CMGMT 39.a: Attachment Q: CFR Weekly Referrals and PMM Meeting 18. DSSLC Policy CMGMT 39.a: Attachment S: Admissions and Transitions Meeting 19. DSSLC Policy CMGMT 39.a: Attachment T: Home Requirements Check List 20. Potentially Disrupted Community Transitions Process (PDCT), revised 12/03/13 21. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 22. Since last on-site review, a list of all individuals who have been referred for placement 23. Since last on-site review, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge" 24. Since last 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. 25. 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 26. Potentially Disrupted Community Transitions with a date range of 7/1/13-6/19/14 27. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 28. For the last twelve months, a list of individuals who were reported to have been assessed for

	placement 29. Community Placement Report (CPR) dated Tuesday, July 22, 2014, with meeting dates from 1/31/2014-7/21/2014 30. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #78, #151, #182, #474, #483, #772 and #791 31. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 32. List of Community tours for the past six months 33. DADS Annual Report: Obstacles to Community Referral and Transition, Fiscal Year 2013 34. Recent Individual Support Plans (ISPs), ISP assessments, ISP Preparation documentation and Preferences and Strengths Inventory (PSI) for Individuals #78, #151, #182, ##474, #483, #642, #772 and #791 35. Individual Support Plans (ISPs), ISP assessments, ISP Preparation documentation and Preferences and Strengths Inventory (PSI) for on-site ISPs for Individuals #113 and #667 36. Denton State Supported Living Center Community Tour Documentation form 37. Community Living Discharge Plan template, revised 06/10/2014 38. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 39. Completed CLDPs for Individuals #332, #457, #622, and #698 40. Partial CLDPs in progress for Individuals #61, #147, #181, #290, #585 and #721 41. CLDP Assessment Checklist, undated 42. CLDP Helpful Hints, undated 43. ISPA for referrals exceeding 180 days for Individuals #61, #147, and #204 44. Pre Move Site Reviews for Individuals #65, #332, #376, #415, #429, #453, #457,#461, #622, #698, #747, and #753 45. Copies of all Pre-Move Doctor to Doctor contact for all transitions in the past six month 46. Copies of all Pre-Placement Medical Chart QA Reviews for all transitions in the past six months 47. Local Authority (LA) Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #65, #332, #376, #415, #429, #453, #457,#461, #622, #698, #747, and #753 48. Post-Move Monitoring Checklist, Form 018D, revised in December 2013. 49. Completed Post Move Monitoring (PMM) checklists for Individuals #332, #622, and #698 50. Potentially Disrupted Community Transition Documentation for Individuals #461 and #611 51. Integrated ISP Monitoring Tool 52. QA/QI Data Meeting, Section T Most Integrated Setting, dated May 27, 2014 **People Interviewed:** 1. Clark Clermont, Director of Community and Family Relations (CFR) 2. Tony King, QIDP Coordinator 3. Shannon Mack, Post-Move Monitor 4. Paul Bezner, Certified Occupational Therapy Assistant (COTA) and Habilitation Therapies PMM staff 5. Lori Powell, Quality Assurance (QA) Director **Meeting Attended/Observations:**

	1. Annual ISP meetings for Individuals #113, #638 and #667 2. Post-Move Monitoring Visit for Individual #457
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The self-assessment rating relied much more substantially on data collected through the Facility's QA/QI processes, including the Integrated ISP Monitoring Tool. Overall, the Monitoring Team found the Self-Assessment to be improved for use in achieving compliance, in that the criteria more often addressed the noncompliant findings from the Monitoring Team and in a more comprehensive manner. While the Facility did reference standards it was trying to meet in some circumstance, it should still consider setting clear provision-specific outcome indicators that could serve as benchmarks for the self-ratings. 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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Monitoring Team continues to recommend the Facility 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. **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: T1b, which the parties agreed would be rated based on the development of an adequate policy.; 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; 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 T1b. **For Provision T2**, the Facility self-rated substantial compliance in Provision T2a. 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 these provisions. **For Provision T3,** no compliance rating is required.

	Provision T4 was not rated, as no alternate discharges had occurred.
	Summary of Monitor's Assessment: 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 continued to develop and implement innovative approaches to addressing obstacles to transition. DSSLC was also to be commended for enhancing staffing resources to support referrals and transitions, particularly in the assignment of a Habilitation Therapies staff to assist with transition activities, including provider training, pre-move site reviews and post-move monitoring. This was a very valuable addition, particularly as individuals with significant physical and nutritional management needs transition to the community. Other specific findings are detailed below: **For Provision T1**, 13 individuals had transitioned to community living and there were 13 active referrals. The Monitoring Team continued to find substantial compliance in several sub provisions, including 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, but was making progress. 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 needed continued improvement in identifying 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 to 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. **For Provision T2**, the Facility reported it was in compliance with Provision T2a, but the Monitoring Team did not concur. The Facility reported PMM Checklists were generally being completed in a timely manner and included visits to all sites at which the individual lived and worked/day activity, as required, but documentation processes made it difficult to fully evaluate this assertion. The PMM Checklists reviewed in depth and the observation of a PMM visit indicated that post move monitoring was not yet conducted in a sufficiently thorough manner. There had been considerable turnover in this position in the past six months, which may have contributed to the concerns noted. 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 remained a significant barrier to an accurate and comprehensive post-move monitoring process. The Monitoring Team also remained concerned that the IDTs were not documenting any review of PMM Checklists. **For Provision T3**, no rating is required.

	Provision T4 was not rated, as the Facility reported no Alternate Discharge during the past six months.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		

T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	<u>Transition Staffing:</u>
		Staffing devoted to transition included the Director of CFR, an Admissions/Placement Coordinator (APC), a Placement Coordinator, a Post-Move Monitor, and two Transition Specialists funded through the state's Money Follows the Person project. In addition, a Habilitation Therapies staff person had been assigned to assist with transition activities, including in-service training, pre-move site reviews and post-move monitoring. The Department of CFR held a weekly departmental meeting to discuss and plan for all transition related activities, which appeared to be of significant value in the transition planning effort.
		
		<u>Transition Outcomes During Last Six Months:</u>
		• Community Transitions: The number of community transitions showed a stable trend.
		  o There were 13 transitions to community living since the last monitoring visit. With 458 individuals currently living at DSSLC, this represents approximately three percent of the population. This figure was a continuing trend since the previous monitoring period in which 14 individuals had transitioned.
		  o The transition process took more than 180 days for ten of the 13 (77%) individuals.
		• Referrals for Community Transitions:
		  o The number of community referrals indicated a declining trend. Ten referrals had been made since the last monitoring visit, according to the Community Placement Report, as compared to 15 in the previous period.
		  o Thirteen individuals were on the active referral list (approximately 3% of the current population at DSSLC).
		  o The CPR indicated that three of the 13 (23%) current referrals had exceeded the 180 days allowed in the current policy and pending revision, but the process of producing the CPR does not provide an accurate picture in regards to timeliness, as it refreshes the referral date at the time of the individual's annual planning meeting. For at least three of the individuals for whom the CPR indicated a 2014 date of referral, the actual date found when reviewing the CLDP in progress was
			Noncompliance

#	Provision	Assessment of Status	Compliance
		in 2013 or before and well beyond the 180 day time period. It was therefore not possible to evaluate timeliness from these data, except to note that the CPR under-represented the number that were within 180 days. o Individuals requesting placement, but were not referred: The Monitoring Team had requested an updated CPR, dated Tuesday, July 22, 2014, with meeting dates from 1/31/2014-7/21/2014. Twenty-one 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 fact, at least some of these individuals were known to have transitioned to the community. 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. • Rescinded Referrals: o There were 11 rescinded referrals reported since the last review, which was a substantial increase over any previous reporting periods. o Of these, three rescissions were as the result of LAR choice, two were due to individual choice and six were related to medical and/or psychiatric issues. o The Facility had developed a Special Review Team (SRT) process which was implemented when a referral was to be rescinded. The SRT was comprised of the QIDP Coordinator, the Human Rights Officer (HRO) and the Assistant Director of Programs (ADOP) or the QA Director. As needed the Chief Nurse Executive (CNE) and Medical Director also served on the team. The SRT was to review the decision to rescind in light of factors such as the individual's wishes, availability of supports in the community, and adequacy of information provided to the IDT. The Living Options instrument and other support documentation were to be reviewed and the SRT could also confer with one or more of the IDT members, including the individual. The SRT's role was not to overturn a decision by the IDT but rather to complete an objective review and provide feedback, consultation and support as needed. As a result of their deliberations, the SRT might also provide additional information and/or staff training to the IDT participants. The SRT was expected to summarize its deliberations and any actions taken on a Special Review Documentation form, with a copy of the form sent to the state office QIDP and Program Services Coordinator and Continuity of Services Coordinator. This was a positive practice which allowed the Facility and the IDTs to examine why referrals may be rescinded, which should also	

#	Provision	Assessment of Status	Compliance
		lead to strategies to minimize these. • Returns from Community Placement o No individuals had returned from a community placement. This number of individuals who returned to the SSLC after a failed community placement indicated a stable trend in line with the previous two monitoring site visits. DSSLC noted in its Report for Monitors that there had been no returns from a community transition for the past five years. • Deaths Following Community Placement: o Since the last onsite review, there had been one death of an individual who had moved from DSSLC to the community. The death occurred 21 months after transition. The IDT did not meet to review the circumstances. The Facility indicated state policy on Potentially Disrupted Community Transitions requires the IDT to meet only if the event occurs within the first 12 months after transition. The Monitoring Team notes that every death that occurs post-transition potentially offers lessons for future transitions and may indicate important trends. The cause of death at least should be reviewed as a part of the State's and Facility's overall quality assurance processes. For example, if the data indicate a large percentage of individuals died as a result of gastrointestinal issues, this might lead the State to examine whether community providers need additional training in signs and symptoms identification. • Other Adverse or Unexpected Outcomes: In response to the Monitoring Team's request for information about specific post-transition outcomes, the Facility provided a list entitled Potentially Disrupted Community Transitions (PDCT) with a date range of 7/1/13-6/19/14. During the past six months preceding this monitoring visit, two of the 13 (15%) individuals who transitioned during that period were reported to have experienced one or more such events since moving. Of these, for neither (0%) was there was documentation provided of an IDT review conducted to determine if changes in the referral and transition planning processes at the Facility should be made. The Facility indicated no reviews were necessary as neither met the state criteria for PDCT. On the other hand, Attachment O to the DSSLC Policy CMGMT 39a indicated the IDT was expected to also meet following "any adverse outcomes or potentially disrupted community transition." The Monitoring Team encourages the Facility to address each adverse or unexpected outcome on an individualized basis, using the PDCT criteria as guidelines only. See Provision T2a.	

#	Provision	Assessment of Status	Compliance
		Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: 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. Several of the positive practices included: • 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. • The Facility had designated a member of the Habilitation Therapy Department, a Certified Occupational Therapy Assistant (COTA), to the Department of CFR to assist with transitions and post-move monitoring. • 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 APC, the Placement Coordinator, the two Transition Specialists, the Transition Specialist Coordinator (a statewide position housed at DSSLC), the Post-Move Monitor and the designated COTA. The group reviewed a tracking database, made any additions needed, discussed issues and problem-solved as needed. This continued to be a commendable practice. • The Director of CFR continued to attend the daily Integrated Morning Report (IMR) meeting and reported weekly on the status of referrals and updated the members on post-move monitoring outcomes. • An Admission and Transitions 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 (CNE), Habilitation Director, 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. a. The Facility continued to implement the Pre-Placement Medical Chart QA Protocol, a Pre-Placement Doctor to Doctor Contact Protocol, with varying degrees of thoroughness. See Provisions T2a and T2b. b. Beginning on April 28, 2014, the Facility had implemented a Special Review Team, described above, comprised of the QIDP Coordinator, the Human Rights Officer (HRO), the ADOP or QA Director, the CNE and the Medical	

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		Director, to review all rescinded referrals. Conclusion: There was continued progress in this area, but the provision was found to be not yet in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 and F2ab); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	Policies and Procedures related to transition and discharge processes: At parties' meetings in July 2012, the parties agreed that the Monitors would rate Provision T1b as just the development of an adequate policy. The sections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of Provision T1b or any of the other cells under T1b. DADS had issued DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spells out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of	Noncompliance

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		Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken <u>prior</u> to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. The policy listed two reviews of CLDPs to be undertaken, one at the Facility and one at State Office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no mention of need for the IDT to use the CLDP to ensure supports are in place. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • To move in the direction of substantial compliance, the Monitoring Team recommends the DADS policy be reviewed for consistency with the metrics submitted by the Monitors and the content of the monitoring reports. The Facility had updated and further localized its own policy DSSLC Policy CMGMT 39.a: Most Integrated Setting Practices: DSSLC Addendum, dated 06/01/2014. This included adding a number of new Attachments that further described details of Facility practices that addressed, in some measure, some of the above deficits in the statewide policy, including: • DSSLC Policy CMGMT 39.a: Attachment L: Plan to Support People to Live in the Most Integrated Setting • DSSLC Policy CMGMT 39.a: Attachment N: Process for Reviewing Obstacles to Transition within 180 Days • DSSLC Policy CMGMT 39.a: Attachment 0: IDT Review of Post-Move Monitoring • DSSLC Policy CMGMT 39.a: Attachment P: Day of Transition Checklist • DSSLC Policy CMGMT 39.a: Attachment Q: CFR Weekly Referrals and PMM Meeting • DSSLC Policy CMGMT 39.a: Attachment S: Admissions and Transitions Meeting • DSSLC Policy CMGMT 39.a: Attachment T: Home Requirements Check List <u>Conclusion:</u> This provision was found to be not in compliance.	
	1. The IDT will identify in each individual's ISP the protections, services, and	<u>Protections, services, and supports:</u> 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	Noncompliance

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	supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	items of section F: F1d, F2a1, and F2a3. As noted above in Section F of this report, substantial compliance was not found for Provisions F1d, F2a1, and F2a3. As documented in Provisions F1d, F2a1 and F2a3, the Monitoring Team found the IDT still failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting. Therefore, substantial compliance was not found for Provision T1b1. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> DSSLC gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles separated into two categories as defined in Exhibit A to the statewide Policy #018.2. The first category, obstacles to referral, included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Medical needs requiring 24-hour nursing services/frequent physician monitoring • Behavioral health/psychiatric needs requiring frequent monitoring by psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff • Evaluation period (Ch55/46B only) • Court will not allow placement (Ch55/46B only) • Lack of funding The second category, obstacles to transition, included: • Lack of supports for people with significant challenging behaviors • Lack of availability of specialized therapy supports • Lack of availability of specialized medical supports • Lack of specialized mental health supports • Need for environmental modifications to support the individual • Need for meaningful employment or supported employment • Individual/LAR indecision • Medicaid/SSI funding • Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual Of eight sample ISPs reviewed, the Monitoring Team found that six should have had obstacles to referral defined. Of these six ISPs, all had obstacles defined (100%), but none (0%) included an adequate discussion of these obstacles to referral. Plans to address	

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		obstacles at the individual level were not adequate for the most part. Of the six ISPs, only one (17%) included an action plan to address/overcome obstacles identified that would be considered minimally adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles.) Examples included: • For Individual #791, the annual ISP indicated the facility discipline members, (independent of the resident and LAR/family) determined the individual could not be served in the community at this time due to LAR Choice. This indicated this particular IDT, at least, did not comprehend its responsibility to provide an independent professional determination prior to considering the issue of LAR choice. • For Individual #78, the obstacles identified included LAR Choice, Individual Choice (related to unknown preference and lack of understanding of community options) and Medical Issues. The latter was the reason the facility discipline members concluded the individual could not be served in a less restrictive setting. The LOD narrative indicated this was based on the current issue of weight loss due to meal refusals, although this had not been referenced in the discussion of the Living Goal section and seven of the nine facility discipline assessments that included a living option recommendation had indicated the individual could be served in a community setting. Only the annual Medical and FSA Summary indicated the individual could not be served, and the Medical Assessment did not state why or include any recommendation related to weight loss. The FSA Summary did not state a clear reason for the determination either, and weight loss was not referenced at all. This was not a new phenomenon for the individual, and the IRRF did indicate the individual was at high risk in the category of weight, but it would appear that if it rose to a level of an obstacle to transition, it should have been reflected as such in some ISP assessment. • For Individual #474, a referral to another SSLC had reportedly been open for two years. The purpose of this intended move was to facilitate family interaction and because the mother wanted the individual to be closer, but the mother was reluctant for community placement due to the individual's limited awareness of the environment, lack of pedestrian safety skills and the individual's impulsivity to leave the home. The eventual determination by the facility discipline members was to continue the referral to the other SSLC and did not definitely state whether the person could or could not be served in a less restrictive setting. The document noted that all team members agreed services and supports could be provided in a less restrictive setting, but indicated Medical Issues as the obstacle. The annual Medical Assessment indicated the individual had relatively few health problems for an individual of that age, so it was not clear what the medical issues entailed. Neither LAR Choice or Individual Choice was selected as an obstacle, and the only Action Plan regarding community living	

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		was annual contact by the Contract LA. There was a skill acquisition plan (SAP) for pedestrian safety skills, which was positive, but there was no clear relationship between the learning of the skills and the potential for community referral. • For Individual #151, the facility disciplines all recommended in their assessments, and as a team, that the individual could be served in a community setting. A referral was not made due to LAR reluctance. Action Plans included Provider Fair and annual CLOIP, but no tours or other actions individualized to the LAR's concerns were planned. • For Individual #772, the facility disciplines all recommended in their assessments, and as a team, that the individual could be served in a community setting. A referral was not made due to Individual and LAR reluctance. Action Plans consisted only of invitation to a Provider Fair and community outings, including grocery shopping once per month and holding an oxygen mask to the face independently. The Action Plans for Living Options that were being tracked in each of the Monthly Reviews had not been updated and did not correspond to the current ISP, indicating they were not likely to have been implemented. The Monitoring Team also observed Living Options discussions at on-site ISP annual planning meetings and expressed concerns about the obstacles discussion observed at the ISP annual planning meeting for Individual #667: • For Individual #667, the IDT made an effort to hold a thoughtful living options discussion. The individual had been referred for transition at the previous ISP annual planning meeting, but the referral had been rescinded within six months. The IDT had 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 previous for a slow and careful introduction to a foster care provider had been attempted, even though it was designed to address the aforementioned sensitivity. The IDT discussion at the current annual ISP planning meeting was observed to indicate that a referral would not be made at this time but a goal was discussed the individual could be prepared for a referral within two years. It was not clear whether this two-year time frame was driven by the amount of time it would indeed take the individual to develop trusting relationships with providers if a concerted effort were made. As the previous plan for this had not actually been implemented, it could not serve as a baseline for making such a projection. There was not a clear rationale provided. • A referral was not made, but it was suggested in the narrative of the ISP that a referral could be made in 2016. The IDT determined the obstacle to referral to	

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		be Individual reluctance. This section also noted the following: "In order to eliminate this obstacle a few concepts have been generated to aide (sic) in the elimination thereof and are as follows: o (The individual) will be provided with opportunities to increase his understanding of community living options through an increase in provided and encouraged outings and tours. It is proposed to have 3-4 offered outings a month and 1of them consist of a community tour. It was noted that the last tour last approximately 30 minutes and that (the individual) was eager to leave promptly after (the individual's) arrival. Therefore it is recommended to slowly increase the time spent at each tour to assist in acceptance to change in environment. o The previous tour was seen to be successful due to longtime friend and building coordinator … who had aided the process with the Active Treatment Tech. It is recommended to continue with the aide of familiar staff and slowly fade them away due to lack of access to the same people upon move. This has also been effective when training new staff…" • It was not clear these strategies differed significantly from those of the previous year that were not implemented. In this current ISP, the Action Plans under Living Options were not sufficiently specific or formal to suggest the outcome would be different from the prior ISP. The primary ISP Action Plan was for the individual "to increase understanding of community living options by increasing the amount of time on outings." There was no SAP or written service objective provided that incorporated the concepts found in the narrative of the ISP described in the previous bullet. The frequency of implementation in the Action Plans was "as scheduled." • The IDT also identified several issues that would have to be addressed in a community living setting, including the potential for increasing environmental adaptations to meet the individual's physical needs. The individual used a wheelchair at times, but also was still able to be independently mobile either with some staff assistance or through crawling. It was noted the individual could use a bench for bathing, but that it was much safer and easier if the bench was in a walk-in shower rather than a tub. It was also reported the individual was able to get in and out of a regular car or van, but the IDT felt a wheelchair van might be needed within five years. • The contribution of the Transition Specialist to these proceedings was not observed to be particularly helpful to the IDT nor positive in nature. She made statements that indicated it would be difficult to get a group home provider to undertake the slow introduction process the IDT recommended, but that it	

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		would be similarly problematic to find a foster care provider willing to make the environmental adaptations to a private home or to purchase a van with a wheelchair lift. One member of the IDT eventually inquired very sincerely whether the IDT was asking for too much for this individual. The Monitoring Team was concerned that the IDT's sense of the possibilities for community living were negatively affected by the lack of encouragement proffered by the Transition Specialist. Preferences of Individuals and LARs The Facility was taking some creative actions to address the unknown preferences of individuals living at DSSLC. In previous monitoring visits, the Facility had described a plan to address these issues, based on a review of ISPs that indicated the largest group of those with unknown preferences was made up of individuals who did not have sufficient awareness to form a preference. 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 was considerably more substantial than in the past. The Department of CFR was collating the responses. It was unclear whether this documentation was yet routinely reviewed by the IDT or used in developing or refining ISP Action Plans related to community living, or if this would be the next step. Preferences of LARs and families for living arrangement were typically more often understood and documented. The Facility was providing some opportunities for families and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. Conclusion: This provision was found to be not in compliance.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices: In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria: An Individualized Plan For Each Individual: The Facility did not yet develop adequate individualized community education plans for each individual. For one of the eight (13%) ISPs, for Individual #182, was there a plan for increasing awareness of community living options that was individualized and took into account the learning needs of the individual. For Individual #182, the facility disciplines all recommended in their assessments, and as a team, that the individual could be served in a community setting. A	Noncompliance

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		referral was not made due to Individual reluctance, based on the individual's statements, but the IDT agreed to continue to provide exposure to the community, including visiting the Transition Specialist four times during the year to view available living options on the computer. The ISP also noted the individual expressed it would be hard to have new friends if a move took place. A relationship goal was established to identify a male companion to go on community outings with, which could assist in addressing this perceived obstacle. While other opportunities existed to expand upon this plan, these were promising and individualized approaches. The Monitoring Team observed the Facility had undertaken some initiatives to improve outcomes in this area. A Corrective Action Plan (CAP) had been initiated in December 2013 to encourage a fuller discussion of Community Living Options at annual ISP planning meetings. This CAP was discontinued and is now instead an ongoing process in which QA, CFR and/or Transition Specialist staff attend ISP's and offer consultation regarding the Community Living Options discussion. The consulting staff also were to provide reminders/prompts during the discussion as needed. This was reported to be a positive experience, although only one referral had thus far resulted from any of the meetings attended. In addition, staff had received training on the development of ISP Action Plans to address obstacles related to individual and LAR reluctance. The Monitoring Team commends the Facility for these thoughtful approaches. <u>An Annual Provider Fair:</u> The Facility holds a Provider Fair on a semiannual basis. The most recent was held on Saturday, March 29, 2014. Attendance tended to remain lower than weekday fairs, but addressed the needs of a group of families, in particular, who cannot attend on weekdays. Overall. 99 people participated in the recent Provider Fair, which was comparable to the attendance at the weekend fair held in March 2013, but considerably reduced from the 315 at the weekday event in September 2013. The Facility continued to complete a survey of the participants in the Fairs. The responses indicated the Provider Fair was helpful overall, but providers felt that holding it once a year was sufficient. They suggested holding smaller family meetings at other times. The Facility used this feedback to develop a monthly coffee shop approach, in which a single provider at a time would be invited to meet with staff, individuals and families in an informal get together at the Wooden Nickel. It was reported this approach had been well received since its recent implementation. <u>Regular SSLC Meeting With Local LAs</u>: 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. <u>Education About Community Options</u>: DSSLC did not yet have a consistent or formalized plan for tracking specific outcomes or measures related to education about community	

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		living, nor for using such information to evaluate opportunities to improve outcomes. Examples included: • IDT Action Plans: DSSLC was still not formally collecting data regarding the development and implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should consider developing a process to do so. • CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of seven CLOIP Worksheets for recent ISPs. For these individuals, five of seven (71%) were visited by the CLOIP Service Coordinator. For none of the five (0%) in which the LA engaged 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, the LA Service Coordinator documented the individual did not seem to comprehend or attend to the material presented. This continued to indicate DADS needs to assess how the process, materials and/or information might be modified to more effectively meet the needs of the individuals. Tours Of Community Providers: The Facility had taken some steps during the past six months to fashion provider tours as a part of an individualized community living awareness and education plan. This represented progress. • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): In previous reports, the Monitoring Team had noted that individuals who did not have an active referral seldom had opportunities to take community tours, resulting in their having no experience upon which to form any preferences. The Facility had recently begun to augment the regularly scheduled CLOIP tours by utilizing its Program Without Walls (PWOW) daytime program to schedule additional tours. It appeared this had a positive effect on increasing opportunities for non-referred individuals. Between 1/15/14-7/16/14, according to the report provided, the Facility documented a total of 25 community tours. An unduplicated total of 35 individuals had participated in the tours. Sixteen of 35 (46%) individuals who participated in tours were those who had an active referral at the time of the tour, while the remaining 19 were individuals who had not yet been referred. The Monitoring Team noted this progress, in that individuals who had not yet been referred were more frequently being offered opportunities to explore community options. This did not appear to yet provide sufficient opportunities for the 458 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in	

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		informed decision-making, but it did represent progress. • 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. • 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, usually no more than four individuals, continued to be conducive to both individual learning and assessment of responses. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. At the time of the last monitoring visit, 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. The Facility continued to use a form entitled Denton State Supported Living Center Community Tour Documentation for this purpose. Staff accompanying individuals were to document the living option toured, a description of the home and a narrative regarding the individual and staff reactions and/or comments. QIDPs and PWOW staff had received training on the expectations for the use of this form. The Monitoring Team requested the tour documentation and evidence of IDT review of the individual's response for all individuals who went on tours in the three months preceding the monitoring visit. While tour documentation varied in its thoroughness, it was available for every individual who had made tours during this timeframe. The Facility was to be commended for its efforts in this regard. Opportunities Are Provided To Visit Friends Who Live In The Community: It was reported that two individuals living at the Facility had opportunities to visit with friends who had moved to the community. Education Provided In Various Venues: The Facility did hold self-advocacy meetings. A review of the minutes for the past six months reflected education about community	

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		living options was included on the agenda in one of seven meetings. Department of CFR staff were reported to attend every meeting. A Plan For Staff To Learn More About Community Options: Staff education and awareness is a key component to reducing obstacles related to reluctance of the LAR and/or the individual. Educational opportunities about community options had been provided through staff participation in community tours, community exploration activities for individuals, and transition related visits. Staff also had the opportunity to attend the Provider Fairs and the Facility documented 34 staff who took advantage of this event in March 2014. The Facility had also published community living options educational materials in the March and June issues of the DSSLC Grapevine newsletter. The Director of CFR also continued to conduct 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, post move monitoring and protections, and the Olmstead decision. Between 1/16/2014 and 6/12/2014, this reached 278 new staff. 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 did not 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 revised policies, procedures,	Percentage of Individuals Assessed as Required: State and local policies require that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. In addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire	Noncompliance

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	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.	team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. The Facility provided a list of individuals who had been assessed for placement in the past twelve months. It also provided the following description of the process in use for this assessment: "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. 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. 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. If the team identifies obstacles that are not addressed through the Individual Support Plan (ISP) itself, they are tasked to create action plans to remove the identified obstacle. Each professional staff required to attend the ISP must make a professional recommendation for the movement answering the question of whether the service could be delivered in a less restrictive setting. They must then make a recommendation based on the unique circumstances	

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		for that individual. Ideally, the individual, LAR, and team must all be in agreement about a recommended choice of living option. However, it is clear that an individual's or LAR decision is final in this area of service decisions. The 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." Overall, the process in use at the Facility to assess individuals for community living continued to be inadequate as an assessment for community placement. Issues that affected the adequacy of the assessment included: • The Facility often did not yet have an adequate basis for determining the preferences of individuals for living arrangements as described in Provisions T1b2 and F1c. While improving, 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. • 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. • For eight ISPs reviewed, there were a total of 77 discipline-specific assessments reviewed. Of these, 72 (96%) included a determination of whether the individual could be served in a less restrictive setting. • Of the 72 assessments reviewed that included a determination, only 14 (19%) included substantive, individualized and discipline-specific recommendations for how the individual's needs could best be met in a more integrated setting. • In six of the six (100%) written ISPs reviewed in which a referral was not made or in effect, 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 still sometimes inconsistent with the professional opinions the disciplines provided in their individual assessments. • While progress was noted, in none of the eight (0%) written ISPs reviewed did a thorough discussion of living options occur (i.e., consideration of different types of community living settings, locations, preferences, safety needs, etc.)	

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		The Facility had implemented a Corrective Action Plan (CAP) on 12/15/2013 to encourage a fuller discussion of Community Living Options. The CAP 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. Since that time, the CAP had been implemented as an ongoing process. See Provision T1b2 for additional details. Conclusion: This provision was found to be not in compliance.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	CLDP Policy and Process: The Department of CFR was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. The statewide CLDP format and template had been slightly revised on 06/01/2014. 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. Timeliness of Development and Implementation of CLDP: The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. The Monitoring Team reviewed a sample of six CLDPs in progress for referrals made during the past six months. There appeared to be no significant delays in initiating these activities following the initial referral meeting or in sustaining that activity at a reasonable pace. The Monitoring Team reviewed the six CLDPs in process to evaluate whether the Facility was compliant with its policy to document transition activity on an ongoing basis. Six of six (100%) CLDPs in progress did provide such documentation in the Transition Specialist notes and 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 Monitoring Team also reviewed an updated CPR, dated Tuesday, July 22, 2014, with meeting dates from 1/31/2014-7/21/2014 which revealed: • The CPR indicated that three of the 13 (23%) current referrals had exceeded the 180 days allowed in the current policy and pending revision, but the process of producing the CPR does not provide an accurate picture in regards to timeliness, as it refreshes the referral date at the time of the individual's annual planning meeting. For at least three of the individuals for whom the CPR indicated a 2014 date of referral, the actual date found when reviewing the CLDP in progress was in 2013 and well beyond the 180 day time period. It was therefore not possible to evaluate timeliness from these data, except to note that the CPR under-	Noncompliance

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		represented the number that were within 180 days. • Ten of the 13 (77%) transitions that had occurred also exceeded 180 days. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. 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 Monitoring Team requested the documentation of these monthly meetings for the three current referrals that were past 180 days according to the CPR. There was an inconsistent approach to meeting this requirement overall. Using the November 2013 referral date provided on the CPR, it would appear Individual #204 should have had meetings in May, June and July, 2014, but the Facility provided documentation only for May and July. The individual's true referral date was actually in November 2012, however, so monthly meetings should have begun even prior to May 2014. Individual #61 should have had meetings monthly since January 2014, but the Facility only provided documentation for February and May. For Individual #147, 180 day reviews should have begun in June, 2014, but the only documentation was for July 2014. On a more positive note, the Facility did provide some documentation of IDT review of transition activities prior to the 180-day threshold for two of these individuals. 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. <u>IDT Member Participation in Transition Process</u>: Ten of the ten (100%) CLDPs reviewed, including four completed CLDPs and six in progress, included adequate documentation to show that IDT members actively participated in the transition planning process. <u>Development of CLDP in coordination with the LA:</u> A review of a sample of four completed CLDPs (for Individuals #332, #457, #622, and #698) indicated that four (100%) CLDPs included documentation to show that the Facility worked collaboratively with the LA. In addition to participation in the referral meeting, the LA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in Provision T1e below. <u>Conclusion:</u> Provision T1c was found to be not in compliance. Overall, the Facility continued to make progress in terms of balancing timeliness of completing a transition with a cautious approach toward selection of the best provider for an individual. There	

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		were still a number of instances in which placements did not occur within the 180-day requirements and the Facility IDTs did not yet routinely meet to review these on a monthly basis as the statewide policy required. The Facility should ensure 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. The Facility should develop and monitor a tracking list of action steps that need to be implemented once a referral is made and make follow-up with IDTs to ensure timely actions when necessary. Coordination with the LA in the development of the CLDP did not appear to be of significant concern at this time. There remained concerns related to the adequacy of the CLDPs that were developed, primarily in the failure by the IDTs to adequately identify the appropriate pre and post move supports for each individual. These deficiencies are described in more detail in Provision T1e 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 four (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. • Training of community provider staff, including staff to be trained and level of training required. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). . • Assessment of settings by SSLC clinicians (e.g., OT/PT) • Collaboration between provider day and residential staff is ensured • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community) • Collaboration between Post-Move Monitor and Local Authority staff Positive findings included: • Four of the four CLDPs reviewed (100%) did clearly identify a set of activities to occur on the day of the move and the responsible staff member. There was no documentation that the activities did indeed occur, however. The Facility had developed a Day of Transition Checklist, as Attachment P to DSSLC Policy CMGMT 39a to be used to document these activities, but no completed checklists were provided for review. • A review of completed CLDPs indicated provider staff were typically very involved throughout the CLDP process. In four of four (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. None of four CLDPs were found to have included all the necessary components, however.	Noncompliance

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		Issues of concern found in review of these activities included the following: • Collaboration between community providers and DSSLC providers was typically not addressed other than prescribed in-service. There were no specific requirements for any clinician to communicate with a counterpart in the community, with the exception of contact between the facility physician and community physician to ensure understanding of health care concerns and any specific actions that should occur quickly. • There were no specific requirements for assessment of settings by specific clinicians prior to the move. As an example of a support that should have been considered to ensure a smooth and safe transition, clinicians from DSSLC could have provided a falls risk/environmental assessment of the new home and day program for Individual #332, who was at risk for falls, or for Individual #698, who was reported to need assistance in certain settings due to a vision deficit. • None of four (0%) CLDPs consistently specified the level of training that would be provided to community provider staff or the competency to be achieved by those trained. <u>Conclusion:</u> This provision was found to be not in compliance.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	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
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	<u>Evidence of individual/LAR participation:</u> Based on review of four completed CLDPs, each (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. The Monitoring Team also reviewed six CLDPs in progress, including the CLDP Profile and the Transition Specialist documentation of transition activities. Only one of the individuals had a LAR, and the LAR was involved in the decision-making process, including attending tours. The remaining five CLDPs in progress did not evidence that family members were regularly consulted or involved in the process, however, even though there was a family member and contact information identified on the initial page of each of the Transition Specialist files. In only one of these was there any notation about family involvement. That family objected in writing to the referral in August 2013, but there was no further evidence of their involvement until January 2014, when they toured a home, and subsequently began guardianship proceedings. This referral had then been placed on hold.	Substantial Compliance

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		Conclusion: This provision remained in substantial compliance. The Facility should make efforts to document any attempts it makes to work with reluctant families to avoid last-minute delays or stoppages in the transition process.	
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: The CLDP 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 four CLDPs for individuals who had transitioned during the past four months and found three (75%) were completed within 45 days. The only exception was the Comprehensive Psychiatric Evaluation dated 11/14/13, with no update notations. DSSLC needed to continue to focus its attention on whether these assessments were adequately prepared as described immediately above. Adequacy and Comprehensiveness of Assessments: 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. Some progress was noted. For example, for Individual #698, the Pre-Placement Medical Chart QA process identified a need to obtain 2013 colonoscopy results in order to develop an appropriate plan. The Medical Assessment and CLDP reflected this was accomplished. On another positive note, the QIDP Summary for Individual #622 addressed recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. 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, however. As described in Provision T1e below, in a review of four completed CLDPs, the Monitoring Team found that the assessments did not consistently address the full array of services and supports needed for each individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. Despite the positive finding regarding the QIDP Summary for Individual #622 described above, most 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. The Monitoring Team also found 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. Examples included:	Noncompliance

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		• For Individual #457, who transitioned on 7/30/14, the Monitoring Team found concerns in several of the accompanying assessments: o The Life Skills Assessment was essentially a composite of information drawn from other disciplines' assessments and provided little specific information that would be helpful to the community provider in developing appropriate day services and supports. Recommendations were limited to the individual continuing to receive day program services and receiving "assistance to complete formal training and activities as needed." o As reported in Provision K5, records revealed this individual was diagnosed with autism and profound intellectual disability, and had an extensive history of self-injury, rumination, pica, sleep disturbance, yelling, and running from staff. The Integrated Behavioral Health Assessment (IBHA), completed shortly before transition, contained several weaknesses that reflected inadequate assessment and potentially impaired the provision of correct and beneficial intervention. Concerning the self-injury, which was noted to be a significant issue during the PMM visit described in Provision T2b below, the function presented in the Determination of Function and Environmental Relation was automatic negative reinforcement in the form of pain attenuation. Anecdotal functional assessments, however, revealed a function of positive reinforcement via obtaining tangibles, while some staff reported evidence of escape from attention as a maintaining function. These discrepancies were not discussed or addressed through additional assessments. • For Individual #698, there were recommendations made within discipline assessments that were not discussed or otherwise addressed in the CLDP, including a recommendations to consider adding a weighted spoon to the individual's dining equipment, as well as a recommendation in the Pre-Placement Medical QA Review to obtain new chest x-ray prior to transition. Conclusion: This provision was not in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: • Expand upon the initiative to ensure the CLDP provides an accurate and complete description of each individual's needs for services, protections and supports.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that	<u>Identification of Pre and Post Move Supports</u>: In none of the four (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	Noncompliance

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	are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	of the following criteria: • The list was comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. o All safety, medical, healthcare, risk, and supervision needs were addressed. o What was important to the individual was captured in the list of Pre and Post Move supports. o The list of supports thoroughly addressed the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of Pre and Post Move supports. o There were Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. o There were Pre and Post Move supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. o Topics included in training had a corresponding Pre and Post Move support for implementation. o The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms. o 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. Examples of deficiencies as to the above criteria in the CLDPs reviewed included: • In some instances, there was improvement noted in the definition of criteria for supports to be provided, but this was variable. Overall, for none of four (0%) CLDPs reviewed were there sufficient descriptions or adequately defined criteria of what the Post-Move Monitor should look for. It still was not routinely specified what the observation or staff interview should reveal. 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. For example, for Individual #457, the level of support required for dependent edema was not adequately described. The support called for the individual to be provided with opportunity to elevate legs "periodically" throughout the day. There was no guidance as to a recommended frequency or definition of any symptomatic criteria staff should observe that would indicate a	

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		need for leg elevation. • For none of four (0%) CLDPs was there an adequate description overall of the level of training to be provided to the community staff or definition of the competency to be demonstrated. This deficiency was underscored in the PMM observed during this monitoring visit, as provider staff were not proficient in providing Individual #457, who had a diagnosis of frequent aspiration, with the required diet texture, nor did they demonstrate knowledge of the PBSP and other important supports. During the PMM visit for Individual #457, the Post-Move Monitoring Team questioned whether community providers could be held to a competency standard before transition is approved. The Monitoring Team believes it is incumbent on the Facility and IDT to define the levels of staff competence that will protect each individual's health and safety, at a minimum, and to ensure these are in place prior to transition. Training should be fashioned based on the individual's needs and the current demonstrated competencies of the provider staff. On a positive note that is illustrative of this approach, training documentation for Individual #457 did indicate that provider staff were trained by DSSLC nursing staff to a competency checklist on suction tooth-brushing. This level of training was not consistently implemented, however. For example, as reported in Provision M3, CLDPs reviewed had training sheets for community placement that listed the training provided by the Facility RN Case Manager to the receiving agency nurse. The training sheets provided only brief summaries of individuals' health status in relation to each identified high and/or medium risk condition with limited instruction of what the agency staff should do. o For Individual #457, the CLDP did not specifically state the staffing level that would be needed to meet the individual's basic needs for health and safety, given their knowledge of the other individual living in the home. See Provision T2b. o It did not appear sufficient attention was paid to Individual #457's past history, and recent and current behavioral and psychiatric problems. The CLDP indicated the individual's rates of self-injurious behavior (SIB) were significantly improved, such that the provider staff need only follow the Facility's Positive Behavior Support Plan (PBSP) and did not require any consultation with a BCBA or psychologist unless the behavior increased. There was not an adequate description of how the provider staff should make this assessment and, as described in Provision T2b below, the individual was observed during the PMM visit to engage in slapping of the head on a repeated basis. The individual also had a history of rumination and pica that were not adequately addressed in the CLDP. Documentation reviewed of provider training prior to transition provided no materials or knowledge testing and was limited to 15 minutes.	

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		Pre-Move Site Visit Completed by Facility: The Post-Move Monitor was reported to be generally responsible for completing the Pre-Move Site Visits reviewed, but other transition staff were also noted to have completed this task at times. 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 13 individuals who had transitioned in the past six months. For the 13 individuals, the Facility provided the date on which the Pre-Move Site Review was conducted 13 (100%). Documentation was provided for 12 of 13. o Thirteen of 13 (100%) were reported to have been completed on a timely basis. o Ten of 12 (83%) Pre-Move Site Review documents clearly indicated a visit to each service provision site was included. For the remaining two, a day habilitation program had been identified, but the Pre-Move Site Review forms indicated only the home was visited. Both also responded in the affirmative that the day program site was generally clean and in good repair, however, so the documentation was unclear. o 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. o The Monitoring Team reviewed the Pre-Move Site Reviews for any testing of staff knowledge of individual's needs for supports, services and protections prior to the move. Only three of 12 (25%) included an expectation for staff interview, and those three did not routinely specify the information to be tested. In two of the three (67%), the staff completing the Pre-Move Site Reviews did not provide any narrative regarding the interview, but simply checked the box that it had been accomplished. o The Pre-Move Site Review for Individual #457 documented the Pre-Placement Doctor to Doctor Contact Protocol had been completed, based upon review by the Post-Move Monitor, but the Monitoring Team found the process had not been completed in a manner that met the expectations. The IPN, dated 7/10/14, indicated only that the PCP spoke to the community physician's nurse. LA Continuity of Care Process: The Monitoring Team reviewed documentation for 13 individuals who had transitioned to the community in the last six months and found that for 12 of 13 (92%) the LA Continuity of Care Pre-Move Site Review Instruments was completed within the required timeframe. One was not dated until after the transition date.	

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		Coordination of CLDP with provider staff: A review of completed CLDPs indicated provider staff were typically involved throughout the CLDP process. In four of four (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. 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: o 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: QA procedures related to ensuring the development of CLDPs included: • A QA Auditor was assigned to monitor Section T. The Facility was using the DADS combined CLDP/PMM monitoring tool designed to incorporate monitoring from the development of the CLDP through PMM activities. One had been completed this far. • The QA Department was also reported to be monitoring to ensure timeliness of the documentation of actions related to referrals and transitions, as follows: o For all new referrals QA tracks whether the profiles have been completed within 10 days of the referral. o For all referrals exceeding 180 days, QA reviews to see if activities related to transition have been documented. o For all referrals exceeding 180 days, QA will review for activities related to transition every 30 days. • The Department of CFR continued to track the provision of the 45-Day assessments by the various disciplines. • A Pre-Move Site Review conducted by Facility transition staff continued to provide an additional layer of scrutiny to verify that essential supports were in place prior to an individual leaving the Facility; however, this process continued to need improvement. See Provision T1e. • The Facility also continued to implement two additional practices related to enhancing the quality of transition planning for individuals who had been referred. These included: o 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	Noncompliance

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		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 received the report. All issues identified were expected to be addressed by the PCP within seven days of receipt. The QA review was required to be completed before the CLDP was held. ○ 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. The Pre-Move Site Reviews reviewed indicated this had been completed, but the Monitoring Team found that in at least one instance, for Individual #457, the process was not completed in a manner that met the expectations. See Provision T1e above. <u>Conclusion:</u> This provision was found to be not in compliance. The quality assurance processes for this Section continued to evolve. The Monitoring Team encourages the Facility to continue to evaluate outcome and process indicators for implementation that will address the deficiencies in Provisions T1c, T1c1, T1d and T1e. 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: • Clear performance goals and outcome measures should be defined, along with appropriate methodology for obtaining the data. DSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility. • Given the concerns related to the adequacy of the CLDP as detailed above, the Monitoring Team again strongly suggests the Facility continue a focused effort within the Quality Assurance Department in conjunction with the Department of Community and Family Relations to improve the quality of all of the processes involved in the CLDP consistent with the findings and recommendations in this report, including the continued development of outcome indicators and monitoring of CLDP assessments, the CLDP meeting, pre-move in-service training implementation, Pre-Move Site Review, and PMM visits.	

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T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	<u>Facility Annual Obstacles Report:</u> The Facility had provided an Annual Report: Obstacles to Community Referral and Transition, Fiscal Year 2013 for review at the time of the last monitoring visit. 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 that time. Obstacles to transition were also identified, with the highest number related to lack of availability of specialized medical supports, followed by Individual/LAR decision. 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. It was noted the DSSLC section of the state-issued Annual Report: Obstacles to Community Referral and Transition referenced below was revised from the November 2013 version described above. While it continued to note Individual/LAR reluctance as the primary obstacles to referral, the primary barriers to transition were shown to be Individual/LAR indecision and lack of supports for individuals with significant challenging behaviors, in that order. <u>DADS Annual Obstacles Report:</u> DADS issued an Annual Report: Obstacles to Community Referral and Transition. It included data as of 8/31/13 from all 13 Facilities and a statewide summary. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12 obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports. • The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times	Noncompliance

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		during the transition process. Further, the data should describe whether these obstacles to transition were overcome. State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report. • DADS strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing...," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. During recent discussion with state office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • 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). <u>Conclusion:</u> This provision was found to be not in compliance.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall	The Facility did provide a Community Placement Report (CPR), dated Tuesday, July 22, 2014 for Meeting Dates 1/31/2014-7/21/2014. It included the following information as further detailed in T1a: • Number and names of individuals placed in the community	Substantial Compliance

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	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.	• Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion and included the required categories. It was noted the CPR under-represented, in some cases, the amount of time to effect a transition because it did not always accurately provide the original referral dates. It was also noted the CPR category for Individuals who prefer community but are not referred for reasons other than LAR choice also contained outdated information, as some of these individuals had transitioned from the Facility more than six months ago. The Facility may want to review the current CPR as well as how the inaccuracies might be remedied going forward.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90	Policies and Procedures related to Post-Move Monitoring: The Facility reported it was using the PMM Checklist, Form 018D, revised in December 2013. Staffing: There had been some turnover in the Post-Move Monitor position since the last monitoring period, as three different staff had filled this role during this past six months.	Noncompliance

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	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.	The current Post-Move Monitor, who had experience as a Direct Support Professional (DSP), Vocational staff and QIDP, had been in the position since mid-June, 2014. At the time of the last visit, the Facility had hired a Master's level Social Worker to assist with both transitions and post-move monitoring, but this was no longer in effect. Beginning in December, 2013, however, a member of the Habilitation Therapies Department had been assigned to assist with PMM duties, particularly as it related to the Physical and Nutritional Management Plan (PNMP). This staff person participated in most PMM visits and reported that his participation would be prioritized for individuals with specific physical and nutritional management needs if the workload required. The Facility was to be commended for continuing to consider additional resources based on the specific needs of those individuals who were transitioning. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for 20 individuals who had moved to the community for both timeliness of the PMM visits and the use of the standardized tool for completing the assessment for the presence of CLDP-prescribed supports. Findings included: • Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner. For 20 individuals, 44 reviews should have been completed since the previous review. Of the 44 required visits, documentation and staff report indicated 44 (100%) were conducted. For one individual (Individual #171) both the 45-Day and 90-Day visits were not completed on time. Otherwise, it was not possible to ascertain with certainty the rate of timely completion. This was due to a lack of clarity in the documentation in some instances. For 16 of the required visits, the Facility had documented the visits took place on more than one date. In thirteen of these, the first date was within the required timeframe and the second was past it. While the document usually indicated both the home and day hab were visited, the notations did not clearly indicate what occurred on the two different dates. Only one provided an explanation that indicated the Post-Move Monitor had attempted a home visit prior to the deadline but had to re-schedule due to the individual arriving late from day hab. • Locations visited: For the PMM visits conducted for which documentation was available and for which the day program had begun, each (100%) appeared to include visits to all sites at which the individual lived and worked/day activity (e.g., day program, employment, public school). It was not always clear in the PMM notes that this was the case, however. For example, for Individual #686, the CLDP called for the Post-Move Monitor to review behavioral data sheets from the home and day hab and interview staff. The 7-Day PMM Checklist indicated the data sheets from both sites were reviewed, but the 45 and 90-Day Checklists referenced only the data sheets in the home. No reference was made	

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		to the day hab program. • Use of Standard Assessment Tool: For the 44 PMM visits conducted for which documentation was currently available, 44 (100%) were documented in the proper format, in line with Appendix C of the Settlement Agreement. Assessment of Presence of Supports Called for in CLDP: The Monitoring Team also reviewed a sample of PMM Checklists for three individuals (Individuals ##332, #622, and #698) 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 three of three 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 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 above and T2b below also call into question whether supports are being accurately assessed. Facility's Efforts to Ensure Supports are Implemented: The PMM Checklists 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 documented follow-up and loop closure. However, there were findings that the PMM process was not consistently as vigilant as necessary. Examples included: • For Individual #698, a support called for the provider to make a list of new preferences from the individual's new environment, which was due on June 6, 2014. At the 45-Day visit on 6/20/14, this had not yet been developed and the Post-Move Monitor noted the staff were encouraged to complete this task. No follow-up action was indicated or documented to ensure this had been completed. • Individual #698 was to have several health care supports completed within 45 days of transition, including having a consult regarding a Pap smear and mammogram and a consult for an EKG. These were marked as NA for this 45-Day visit, which occurred 39 days after transition and no comments were provided by the Post-Move Monitor regarding the plan to obtain these prior to the 90-Day visit in the body of the PMM Checklist or in the Post-Move Monitor Follow-up Activities section. ISPA meetings following PMM visits:	

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		DADS Policy addressed special concerns that arise after the move, but did not require an IDT review after each PMM visit or the expectations for this review, including required timeframes. There was not a clear process in place to determine what might constitute a special concern that would require IDT review, however; it was reported this relied primarily upon the Post-Move Monitor, perhaps in consultation with other Department of CFR staff, to identify such a need. It was further reported the Facility required IDT review of the 90-Day PMM Checklist at a minimum, as outlined in Attachment 0 to DSSLC Policy CMGT 39a: IDT Review of Post-Move Monitoring, but the Monitoring Team requested all such completed reviews for the past six months and the Facility responded there had been no IDT review of PMM Checklists during that timeframe. This was particularly concerning to the Monitoring Team, as there were instances in which IDT review appeared to be called for. For example, for Individual #461, the 90-Day PMM Checklist on 07/09/14 documented the individual had sustained three falls with injury between 4/23/14 and 6/11/14, including one that required an ER visit and two that caused injury to the head area. There was no evidence provided that the IDT had reviewed the initial injury requiring an ER visit or any of the PMM Checklists, including the 90-Day Checklist. It was noted by the Facility the above situation did not rise to the level of IDT review for Potentially Disrupted Community Transitions (PDCT) because this is only required after three ER visits. Three falls with injury in less than two months, as documented in the PMM Checklist, should have been of sufficient cause for concern to call for an IDT review regardless of whether this met PDCT criteria, but even more particularly since the 90-Day PMM period was concluding. Transition staff, the Facility and the IDTs must consider the circumstances of each situation and use the PDCT guidelines as just that. Regardless, the Facility should have also ensured its policy for reviewing all 90-Day PMM Checklists was followed. <u>Barriers to thorough PMM Review and Improvements Needed in Monitoring:</u> 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 pre and post-move supports, as described in Provision T1e. 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. Both members of the PMM team indicated they would like to have more specific criteria and monitoring parameters to assist their efforts. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team would like to note that the best examples observed of PMM Checklists from this monitoring visit, for thoroughness, detail and documentation of follow-up, were	

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		completed by a Post-Move Monitor from another SSLC who had a brief stint at DSSLC during this six month period. These may be used as examples for the new and less experienced Post-Move Monitor.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	<u>Observation of Post-Move Monitoring Visit:</u> The Monitoring Team accompanied the Post-Move Monitoring Team on the home visit portion of the 7-Day PMM for Individual #457. The PMM visit to the day program site was reported to have been done the previous week. The CLDP and accompanying assessments were also reviewed. On a very positive note, the Monitoring Team observed significant value added to the process with the participation of the Habilitation Therapies staff, who was able to provide much-needed coaching and additional training to the provider staff. Overall, however, the PMM process lacked the requisite level of rigor needed to ensure all supports were in place and provided. The Post-Move Monitoring Team did not adequately assess for the presence of all required supports. Their ability to monitor effectively was hampered by the lack of sufficient criteria in the CLDP, as described in Provision T1e. The CLDP for this individual still indicated in many 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. In many instances, the Post-Move Monitoring Team's approach, in which questions were posed by providing the correct response and asking for affirmation, did not actually test the knowledge of the provider staff. Examples of deficiencies in the process also included: • Of particular concern, the provider staff on duty stated repeatedly that she was not able to implement all the required supports due to the competing workload needs presented by the two individuals living in the home, both of whom were large, used wheelchairs and required assistance for mobility, and had various requirements for diet textures. The staff person noted she was usually on duty alone and had been asking for additional help. During the PMM visit, the staff person clearly struggled with juggling the demands of medication administration and meal preparation, even though a second provider staff, who was not typically in the home, was on-hand for the PMM visit and assisted with basic supervision needs. There were also significant issues with achieving the appropriate diet texture for Individual #457. While the coaching of the Habilitation Therapies member of the Post-Move Monitoring Team helped to ensure dining and medication administration were safely completed, it was clear both that the provider staff did not have adequate competency in this regard and that she was not able to manage all of the requirements for this individual and the housemate. This meant Individual #457 may easily have been receiving for	Noncompliance

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		the first seven days since transition a diet texture that would increase the risk of aspiration pneumonia. The provider staff further acknowledged that she was not able to complete the check and change schedule requirements in the afternoons and had to postpone meeting this need until after mealtime. The Monitoring Team was also very concerned that having only one staff on duty potentially compromised the safety of the individuals in the home in the event of a fire or other emergency, particularly if both individuals were in bed at the time. The Post-Move Monitoring Team indicated they would follow up with the provider on this issue, but did not fully appreciate the urgency with which this follow-up needed to be implemented. It was recommended to the Post-Move Monitoring Team that the Facility take immediate action to re-consider whether this would be a safe environment with only one staff person. • The Post-Move Monitoring Team did not inquire as to whether the provider had contacted the individual's family as prescribed. • The Post-Move Monitoring Team noted the head of bed was not at the required 15 degree angle and pointed out to a provider staff it should always be at the mark that had been placed on the bed for reference. This provider staff was not one of the regular staff that would be on duty at the home, however. There was no further discussion as to the requirements for head of bed elevation or the reasons it was needed. • There was no discussion with provider staff about the individual's aspiration diagnosis or how certain supports related to that risk. • There was no discussion about the individual's having a pacemaker or of the signs and symptoms the provider staff should watch for related to the bradycardia diagnosis that necessitated the placement of the device. • There was no discussion with the provider staff about the individual's extensive gastrointestinal diagnoses, other than to review the bowel movement log. Upon noting that the log had some missing documentation, the Post Move Monitor asked the provider staff at what point a nurse would need to be notified if no bowel movements were documented. The CLDP indicated a nurse should be notified if there were none in two days, but the provider staff stated the answer was three days. This was not corrected by the Post Move Monitor. • The provider staff was observed by the Monitoring Team to administer calcium to the individual; it was later noted in review of the Medication Administration Record (MAR) that calcium had been discontinued, but no notation as to why. The PMM had not observed that it had been administered, but stated an intention to follow up as to the reason for discontinuation. • The individual engaged in a significant amount of face-slapping during the PMM visit, and provider staff made efforts to block and re-direct. The Post-Move Monitoring Team did not ask provider staff to describe the PBSP provided by the	

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		Facility to address this issue. The only question by the Post-Move Monitor related to this was whether the individual had hit himself hard enough that a nurse needed to be called. No data were recorded. See also Provisions T1d and T1e. • As described in Provision T1e, the individual had a diagnosis of dependent edema and a support called for the individual to be provided with opportunity to elevate legs "periodically" throughout the day. There was no guidance as to a recommended frequency or definition of any symptomatic criteria staff should observe that would indicate a need for leg elevation. This was not discussed, nor was the individual offered any opportunity to elevate legs over the course of the PMM visit. The individual was not using the tilt-in-space wheelchair with elevated leg rests as described in the CLDP, such that the individual's legs hung down throughout the visit. The Post-Move Monitoring Team did not interview the staff about the issue of leg elevation. <u>Conclusion:</u> 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: • Provide additional training to the recently-appointed Post-Move Monitor, preferably through pairing him with an experienced counterpart. • Develop and implement a focused 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 ProvisionT1e. The Monitoring Team further recommends the QA Department be integrally involved in this effort.	
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-		

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	ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	The Facility reported there were no alternate discharges during the past six months.	Not Rated

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. **People Interviewed:** 1. **Meeting Attended/Observations:** 1.
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The parties agreed the Monitoring Team would not monitor this Section, due to limited progress. Therefore, the ratings of noncompliance remain.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.		Noncompliance

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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.		Noncompliance

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. DSSLC Self-Assessment 7/3/14 2. DSSLC Action Plan for Compliance Visit Round 8 (undated) 3. Presentation Book for Section V 4. Provision Action Information for Section V 5. DADS Policy 020.1 Recordkeeping Practices 3/05/10 6. DSSLC Policy CM-25 Recordkeeping Practices 2/6/13 7. Policy CM-25 Recordkeeping Training Materials, including documentation quiz 8. List of all new and revised State and Facility policies implemented since the last compliance visit. • For each such policy, a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools. 9. List of policies by Settlement Agreement Section addressed (crosswalk) 10. New Employee Follow Up Audit Individual Notebook form 11. New Employee Documentation Tracking graph 12. Active Record Order & Guidelines 6/9/14 13. Master Record Purging Schedule 10/15/13 14. Individual Notebook & Guidelines—Extension of the Active Record 9/18/13 15. Active Record, Individual Notebook, and Master Record for Individual #744 16. Settlement Agreement Cross-Referenced with ICF-MR Standards (Section V monitoring tool) 10/9/12 17. Active Record Order & Guidelines Audit Tool 12/11/13 18. Individual Notebook & Guidelines Record Audit Tool 12/11/13 19. Record Audits, including emails regarding corrective actions for 15 audits conducted April, May, and June 2014 for Individuals #177, #189, #206, #208 (April and June), #251, #257, #365, #380, #527, #600, #608, #668, #699, and #727. Audit documents reviewed included the Settlement Agreement Cross Referenced with ICF-MR Standards Section V form (the Section V monitoring tool), Individual Notebook & Guidelines Record audit tool, Active Record Order & Guidelines Audit tool, and emails and other documentation related to corrective actions needed 20. Quarterly data report for Section V of 5/27/14 for QA/QI Council Data Review Meeting with data through April 2014 21. Recordkeeping Report to RSMT for April 2014 and May 2014 22. Summary of Records Changes 23. Summary of Records Changes, Definitions of assessment saved under the virtual folder 24. Records Clerks Delinquency Lists for the week of July 16 2014 25. DSSLC Monthly Audit Tracking February 2014-July 2014 26. Chart Check Follow-up Plan of Correction (undated) including monitoring form 27. ISP Preparation Meeting-Guide for Individual #235

	28. ISP Tracking Audits form containing 99 individuals 29. Active Record, Individual Notebook, and Master Record for Individual #744 30. Guide for Using ISP Monitoring Tool (undated) including instructions and definitions 31. Section F Self-Assessment: Tracking spread sheet for assessments due 12/01/2013 through 06/01/2014 32. ISP assessments tracking log for ISPs conducted or scheduled since the last review, data from April 2013-April 2014 33. ISP Monitoring Tool 34. Integrated ISP audit data for Section V January-June (no year specified) 35. DSSLC Monthly Audit Tracking database reports for July 2013-July 2014 36. Email from Melissia Steele of 5/30/14 containing corrections needed as indicated from the record audit for Individual #527 and attached responses/evidence of corrections 37. Active Record and Individual Notebook for Individual #527 38. ISPs, assessments, and handouts for ISP annual planning meetings for Individual #638 39. Handouts for ISP Preparation Meeting for Individual #235 40. Residential Services Management Team (RSMT) Report (undated, data through May 2014) **People Interviewed:** 1. Joint Interview of Melissia Steele, Unified Records Coordinator (URC) and Betsy Knight, Records Administrator regarding recordkeeping 2. Lori Powell, Director of Quality Assurance, regarding policy development and implementation, and record audits 3. Joint interview of Tony King, QIDP Coordinator, Julie Kuester, QIDP Educator, and QIDPs David Bailey, Kyonia Mosley, and Bryan Mitchell **Meetings Attended/Observations:** 4. ISP Annual Planning Meeting for Individual #280 and #638 5. ISP Preparation Meeting for Individual #235 6. Change of Status (COS) meetings for Individual #684 7. Records storage areas for apartments 505B, 512A, 526 D, and 527B
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section V, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: The monitoring/audit tools the Facility used to conduct its self-assessment included: ▪ The Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 ▪ Active Record Order & Maintenance Guidelines (AROG) Audit tool

	▪ Individual Notebook & Guidelines—Extension of the Active Record audit form ▪ Interview questions for V4 ▪ ISP Monitoring Tool ▪ Shared Virtual Folders Audit tool (which the Self-assessment noted did not have enough data yet for trending purposes) o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement for Provisions V1, V3, and V4. o The monitoring tools included adequate methodologies, such as audits of records and observation of meetings with documentation of specified actions. o The Self-Assessment identified the sample(s) sizes but did not include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. Random record audit and staff interview sample sizes were adequate to consider them representative samples, but it was unclear whether the sample size for ISP auditing was adequate to ensure representativeness. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools (as reported in interview and document request, not in the Self-assessment): ▪ For Section V records audits: Melissia Steele, Unified Records Coordinator, and Records Clerks ▪ For the ISP Monitoring Tool, Sarah O'Bryan, Program Auditor o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were programmatically competent in the relevant area(s). o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the record audit tools but was not reported for the ISP Audit Tool. ▪ Used other relevant data sources and/or key indicators/outcome measures, including: o Percent of provisions covered in either State or local policies o Percent of assessments filed timely ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o For Provisions V1, V2, and V4, presented information specific to each topic heading in the last compliance report. o Presented findings consistently based on specific, measurable indicators. For example, data on compliance with Appendix D requirements was broken out by requirement and month so that trends could be identified. o Consistently measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following provisions of Section V: Section V3. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to

	achieve compliance with Provision V1. ▪ Actions were reported as Actions were reported as Completed, In Progress, or Not Started. ▪ Based on documentation and interviews, it was clear the Facility identified areas of need and improvement, as well as some factors contributing to lack of compliance; these were not limited to issues identified from data in the Self-assessment. The Action Plan identified several of these issues, such as the need to follow up on a sample of employees who need retraining on recordkeeping practices and after orientation, and implementation of a new Check out Card audit process, as the Self-assessment identified a continuing need to improve even though an audit process had already been put in place. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section. Some actions involved at least some sequential steps (such as the process to ensure all required documents are kept current at all programming areas, which started with creating an audit tool and then planned a step to train Program Monitors to complete the audit tool). Others provided detail of the action, such as the new Check out Card audit process. Although more sequential steps may be required, the steps listed should be appropriate for the next six-month period.
	Summary of Monitor's Assessment: The Facility maintained a unified record for each individual. Compliance with Appendix D requirements had shown slight declines since the last report period, but the Facility has taken steps to address that by providing data to residential managers so that they can act to improve compliance. **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. The Facility showed slight declines in the level of compliance with Appendix D requirements compared to that found at the last compliance visit. This was in spite of having a robust audit system. The Facility had taken new steps to improve, primarily through providing data to the residential management staff along with expectations they will take responsibility for improvement. **Provision V2:** The Facility has policies to cover most provisions of the Settlement Agreement; adoption and localization of some State Office policies, and ensuring all requirements of provisions are addressed, should address nearly all provisions. Procedures for routine review and revision of policies are lacking. Procedures for identifying who needs to be trained and the kind of training to be provided, and for ensuring training has occurred, need to be formalized. There is no efficient way to ensure timely that all staff needing training have been trained. **Provision V3:** This provision continues to be in substantial compliance with requirements. The audit system continued to be robust and comprehensive. At least five random audits were conducted each month. Reliability across auditors was adequate, although there arose a concern about independence of the reviews. The Facility has a system for tracking corrections that tracks deficiencies until there is evidence they have been corrected. Although substantial compliance will be continued, two issues constitute a temporary failure to comply during a period of otherwise sustained compliance. The first of

	these is the shift of the definition of falsification that suggests that Interrater reliability monitoring may not be entirely independent. The second is that, contrary to prior reporting periods, there was a decline in compliance with Appendix D requirements; however, the Facility has taken action to address the lack of improvement. **Provision V4:** Records were generally accessible. Some problems were identified in entering data and information timely. Timeliness of assessments so they are useable in preparing for ISP planning needs further improvement. The Facility's data and Monitoring Team observations of meetings showed improvement in presence and use of records but still some inconsistency, indicating a continuing need to improve use of the records at meetings for decision making.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	<u>Policies Governing Recordkeeping</u> The Facility had a policy to maintain a unified record; this policy, which was unchanged since the last compliance visit, 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. <u>The Facility Maintains a Unified Record for Each Individual</u> The Facility Self-Assessment reported that 461 of 461 (100%) individuals have an Active Record and an Individual Notebook; a review of 188 reviews "(163 completed by QA and 25 completed by RCs)" found all had an Active Record, Individual Notebook, and a Master Record. 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 #744. In addition, the Monitoring Team reviewed the Facility record audits from April, May, and June 2014 to determine whether they reported the presence of all three required components. The Facility maintained a Unified Record for each individual. The unified record at DSSLC consisted of an Active Record, Individual Notebook (called the All About Me book), and Master Record. In addition, assessments and some other information were copied to a share drive that was not considered part of the unified record but allowed information to be easily accessible to members of the IDT. The Active Record was the primary document with information about the individual's current status and about the supports and services being provided. Active Records were filed in two, three, four, or (for some individuals with complex medical conditions) more	Noncompliance

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		binders (up to seven in the Infirmary), depending on the amount of documents involved. An Active Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every binder. The Individual Notebook (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 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. The Master Record contains a variety of documents, such as legal documents including birth certificate and guardianship papers. Since the last compliance visit, the Facility had added the Bedside Swallow Evaluation in the Habilitation Therapy section of the Master Record. When documents are purged from the Active Record, they are to be sent to Central Records. Records clerks put overflow/purged documents into boxes and ship them to the records storeroom. This can result in purged documents being out of the active record but not yet in an overflow record for several weeks. Staff needing records can contact the Records Department and request that documents be retrieved. The Facility does not have a way to know if all purged documents are put into the boxes, but records audits (see Provision V3) identify whether records have been purged per the Facility's guidelines. To ensure purged documents are accounted for and remain available, the Facility should consider developing a process at least to identify what documents have been purged and are in the boxes. Based on audits conducted by the Facility, 15 of 15 (100%) audited records included an Active Record, Individual Notebook, and Master Record. In addition, the Monitoring Team audited the record for Individual #744 and found it included an Active Record, Individual Notebook, and Master Record. 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. Audits of 15 records conducted by the Facility in April, May, and June 2014 found 15 (100%) had an Active Record, an Individual Notebook, and a Master Record. Facility trend reports documented each month that 100% of records included all three	

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		components. Staffing and Responsibility for Filing in the Record The Facility had staff assigned to oversee the Unified Record. The Facility had one Unified Records Coordinator (URC) 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 and reported to Unit Directors. Unit Directors were responsible for compliance with requirements for records. To assist Unit Directors, the Facility provided information in a Residential Services Management Team (RSMT) Report; the Section V portion of this report is described in Provision V3. Training of Staff on Documentation The Facility provided training materials for an orientation course titled Recordkeeping. This included training on documentation, including Appendix D guidelines, as well as information on the types of records and the Active Record Order and Guidelines. The training included practice and a competency test on documentation. The Facility had developed an audit process to follow up a sample of new employees. The Facility had begun to pilot this at one Unit prior to the last compliance visit and had implemented a Facility-wide pilot since the last visit. At least five individuals from each monthly orientation class are selected for follow-up monitoring during the following month. For each selected staff, the URC pulls three Individual Notebooks to monitor documentation using the Section V Monitoring Tool. The URC identifies corrections that need to be made and either discusses them with the staff as a training opportunity or notifies the staff's supervisor of the need for corrections. The URC uses the same definitions as used in random records audits and makes a global determination of whether the documentation is in compliance with requirements. The Self-Assessment reported documentation for 11 of the 15 staff followed with these audits (73%) complied. This has the potential to be an effective process to generalize learning to actual performance. The plan was to review the effect of this process following three months of these audits. The process has been in effect for three months, and the plan is to continue while determining whether there are needs for revisions in the process. The most significant finding to date involved legibility. Accessibility and Security of Records To assess whether records were accessible to staff for use in providing supports and in making decisions, and were secure, the Monitoring Team observed the records at apartments 505B, 512A, 526 D, and 527B, reviewed the last 15 Facility audits, and reviewed the data provided for the data analysis report with data through April 2014.	

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		For two of two individuals checked (100%), the Individual Notebook was readily accessible. For five of six individuals checked (83%), the Active Record was readily accessible. For the other individual (Individual #379), the Active Record had been appropriately checked out per the Facility's checkout process. Therefore, for six of six individuals (100%), the Active Record was either present or checked out. Audits of 15 records conducted by the Facility in April, May, and June 2014 found 15 (100%) records were accessible. In addition, reports from Monitoring Team members reviewing records for other sections of this report also indicated records were consistently accessible. The Facility had a process for checking out Active Records. Each apartment had a checkout book in the chart rack where Active Records were kept. The Monitoring Team checked the checkout book for Individuals #37, #147, #239, #379, #527, and #744. The checkout book was present in four of four apartments (100%). All charts were on the unit for five of six individuals. For Individual #37, one chart was out of the apartment being used in the unit by the nurse but was not checked out; staff initially explained it was probably at the clinic (to which it had been checked out five days earlier and not checked back in) but were able to find it after checking with the nurse at the unit. All charts were out of the apartment and appropriately checked out for Individual #379. For Individuals #37, #239, and #744, charts were present but had not been checked back in after the last time they were checked out. Thus, the checkout system was not accurately followed, making it less useful than it might be. The Facility had developed but not yet implemented a Chart Check Follow-up Plan of Correction in which Record Clerks would check the sing out/in binder at least four times per month for one home (and could do more if problems were found) and provide notice to Building Coordinators, the Unit Director, and the URC. This project responded to a recommendation made in the last compliance report. <u>Accuracy, Completeness, and Timeliness of Records</u> 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 Individual #744, data from the May quarterly report for Section V, and data from the 15 audited provided for April, May, and June 2014. Individual #744 was selected by computer randomization out of the admissions since the last compliance visit. The Monitoring Team audited this records using the same audit tools used by the Facility--the Active Record Order & Guidelines Audit Tool and the Individual Notebook &	

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		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. Many documents are not applicable in each record. The Monitoring Team made an effort through review of other documents in the record to determine whether such a document, if not in the record, was applicable. For example, if an individual had in the record an action plan with a specific learning goal, there would be an expectation that a matching Specific Program Objective/Skill Acquisition Plan would be in the appropriate section of the record. For Individual #744, 63 documents were present in the Active Record, 16 required documents were not present, and 176 documents were not applicable. Therefore, 63 of 79 documents that should have been in the Active Record (80%) were found in it. In the Individual Notebook, 12 of 12 required documents (100%) were present, and 8 documents were not applicable. In total, 75 of 91 applicable documents (82%) were present. Review of this individual's Master Record indicated required documents were present. The percentages of documents found present in the Active Record and the Individual Notebook were similar to those found in different records at the last compliance visit, with a lower percentage for the Active Record and a higher percentage for the Individual Notebook. 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. 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). • For Individual #744, 56 of 63 present documents in the Active Record (89%) and seven of 12 present documents in the Individual Notebook (58%) met Appendix D requirements; in total, 63 of 75 present documents (84%) met Appendix D requirements. The Monitoring Team's audit using the Section V	

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		Monitoring Tool found 20 of 27 applicable Appendix D items (74%) to be compliant. These findings were similar to those at the last review. Data from audits of 15 records showed percentage of compliance as shown in the table below: **Section V Monitoring Tool** Range: 62%-92% Mean: 75% The mean percent of documents present was lower than the mean of 84% found in audits during the last review period. It was nearly identical to that found in the review of the record for Individual #744. The Facility provided trends data through April 2014 for compliance with the Section V monitoring tool items. • The overall average of compliance on the Section V monitoring tool from May 2013 through April 2014 showed stable data with a slightly decreasing trend line; this continued the slightly decreasing trend line found during the prior six months. Compliance since the last compliance visit was 70.7% in January 2014, 76.6% in February, 83.3% in March, and 74.7% in April. Overall compliance was calculated from only certain items on the Section V Monitoring Tool. The Facility reported these were items V3.2, V3.4, and V4.1 on the monitoring tool. These included most Appendix D requirements such as legibility and providing information that is adequate for use in routine decision-making and review, whether there was evidence of falsification of records or inaccurate record-keeping practices, whether records are secure, and whether records are used in decision-making. It did not include whether the Unified Record included all three components. Interestingly, compliance for the April 2014 audits provided to the Monitoring Team was higher, averaging 85.4%. This disparity certainly was affected by not including the three items regarding presence of components of the Unified Record. • 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 85% of staff interviewed indicated use of the record. For Appendix D, 47% of requirements were rated as compliant. Eighty-nine percent of records	

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		were secure, 62% were accurate, and 80% 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. The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included: • A test of intellectual ability for Individual #682 was found in the Active Record for Individual #542. • As reported in Provision J2, psychiatric diagnoses were included in the Active Problem List (APL) that listed all medical diagnoses. The Monitoring Team examined 20 clinical records and compared the current psychiatric diagnosis and the APL. For 18 of 20 (90%) individuals, the two sources matched. In two of twenty (10%) the APL had not yet been updated. • As reported in Provision O7: o Aspiration trigger sheets contained multiple gaps in data due to lack of completion. o Triggers when occurred were not consistently documented on the trigger sheet. • As reported in Provision M1: o Documentation errors were not consistently corrected properly with a straight line drawn through the entry, dated, and initialed. o Continuation nurses notes did not consistently carry over the dates and/or times to the next page. o The time and/or dates of entries into the Integrated Progress Notes were not consistently included. o The legibility of the nurses' handwriting had somewhat improved but there was continued need for nurses improve the legibility of their notes, signatures, and titles. • As reported in Provision M6: o Review of the July 2014 MARs for individuals in Garden Ridge found several medications were neither initialed nor circled. The Nurse Manager should review the July 2014 MAR for medications that were neither initialed nor circled and investigate for medication variances. o A review of the units/homes and Infirmary Universal Signature Sheets found that a few nursing signatures were missing corresponding initials. The Nurse Managers should review all Universal Signature Sheets to ensure that all nurses who provide medication administration have signatures and corresponding initials. • As reported in Provision F2d, some monthly QIDP reviews were not signed and	

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		dated upon completion. Use of Share Drive and Electronic Records 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 Active Record are also posted to the Share Drive, including ISPs and ISPAs. The Facility provided a document titled "Summary of Records Changes" that appeared to be communication to staff and gave instructions about what documents would be placed in "the Virtual folders" by professional staff, how the "D-List" (deficiency list) would be used to minimize and correct absence of documents, that records clerks would print documents in the Virtual folders and file them, and plans for further actions. A separate document provided additional information on requirements for filing of some specific document in the Virtual folder. In addition, the Facility used the Avatar electronic records system for some documents. Conclusion The Facility showed slight declines in the level of compliance with Appendix D requirements compared to that found at the last compliance visit. This was in spite of having a robust audit system. The Facility had taken new steps to improve, primarily through providing data to the residential management staff along with expectations they will take responsibility for improvement. To move toward compliance with this provision, the Monitoring Team recommends the Facility ensure the new and planned process are effective by: • Tracking the results of the planned audit of the checkout books and taking action as needed to ensure they are available and are used accurately. • Assessing whether providing data to residential management staff results in improvements in recordkeeping and, if further improvement is needed, implementing additional actions. • 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	Facility Process to Develop and Revise Policies The Facility reported there had been no change in policy or process for developing and revising policies. DSSLC Policy ADM 1-01 governed policy development; the process	Noncompliance

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	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.	established in this policy was described in the last compliance report. As stated in the last compliance report, the Facility had initiated use of a policy committee to review drafts and to identify who needed training, but that committee had not met regularly, so the former process was in effect. That continued to be the case through this review period. 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. <u>Training on Policies</u> The Director of QA reported that the program writer proposes who should be trained; the Executive Management Committee reviews and propose revisions in the type of training to be provided and who requires training, and the Facility Director provides final approval. The Facility did not have a working database to track training provided. Prior attempts to implement a database were unsuccessful, and the Facility reported it considering another process. The policy holder (policy writer) is responsible for ensuring training is done; for ongoing training (for example, coverage of policies in new employee orientation), the Competency Training and Development department is responsible. To achieve substantial compliance, and to improve compliance with new and revised policies, the Monitoring Team recommends the Facility establish a process to ensure training occurs and to document who has been trained. <u>Development and Revision of Policies to Implement Part II of the Settlement Agreement</u> 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. In its Self-assessment, the Facility reported that 99% of Settlement Agreement provisions were covered in either State of local policies, with one provision (Provision K13) not covered. 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 crosswalk of provisions with the covering Facility policy/policies. This crosswalk 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 crosswalk also had a column for comments that included comments from	

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		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. The crosswalk verified that 99% of provisions are addressed; it could not, however, verify that policies address all requirements of all provisions that need policy direction. The quality and comprehensiveness 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. The State Office crosswalk identified one provision that did not have policy guidance. This was Provision K13, which dictates a minimum ratio of staff who are qualified to develop individualized services and comprehensive programs for individuals who require a PBSP, and assistants for those professionals, to individuals served. Prior reports, and recent reports from other facilities, indicated that there remains a need for greater guidance on a systematic and effective process to evaluate capacity to make decisions; because the parties agreed that Section U of the Settlement Agreement would not be monitored at this visit, the Monitoring Team did not review Facility policy, but the list of new and revised policies did not indicate this had changed. As found during the last compliance visit, the crosswalk identified that policies addressed both provisions of Section U, but the Monitoring Team determined at that time that this essential item had not been addressed. The Facility did not have a process in place for routine and periodic review of policies. 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. The Facility provided a list of 16 DSSLC policies and three DADS policies that had been implemented or revised between 12/20/13 and 6/20/13. The Provision Action Information for Provision H7 listed two policies revised since the last compliance visit but not included in the response to a request for a list of new and revised policies, and other policies were identified during the review. These included: • DSSLC Policy C&C-14: Ethics Committee Policy 2/14/14 • Medical 08: Life Sustaining Treatments Policy 4/8/14 • DSSLC Policy CMGMT 34 Occupational/Physical Therapy Services 3/3/14 • DSSLC Policy CM14 Addendum H (To State Policy) At Risk System 6/20/14 Establishment and revision of policies continued. During the compliance visit, the Facility	

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		also provided CMGMT-01B Late Reporting 6/25/14. Not all revised DADS policies were included in the document request response. In addition to those on the list provided by the Facility, DADS had revised Policy 001.2: Use of Restraint 4/4/14. In addition to Facility and DADS policies, the Facility continued to expand and revise departmental policies and procedures. For example: • Section M of this report describes several new nursing procedures and processes. • In Section N, new and revised policies for dental services are described. <u>Implementation of Policies</u> Although policies were generally followed, the Monitoring Team found instances in which implementation was not consistent. • As reported in Provision D1, there were numerous instances of late reporting of suspected abuse or neglect. Furthermore, staff who were asked questions about the abuse and neglect policy did not consistently provide correct answers. • As reported in Sections J and Q, programs to minimize need for use of medical and dental restraint are not yet consistently in place as required, although efforts are under way to improve. <u>Areas in Which Efforts Are Needed</u> 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: • 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 death and to make systemic recommendations for care. Following this visit, a new policy was put into effect. It will be reviewed at a future visit. • DADS policy addressing guardianship and rights assessment 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. 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:	

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		• As reported in Provisions T1e and T1f, the Facility had established a policy that required a pre-placement Doctor to Doctor contact to ensure information on health needed to facilitate a successful transition was communicated. The Pre-Move Site Reviews reviewed indicated this had been completed, but the Monitoring Team found that in at least one instance, for Individual #457, the process was not completed in a manner that met the expectations. • As reported in Section F, DADS and Facility policy require that an ISP preparation meeting be held approximately 90 days before the annual ISP planning meeting for an individual. At that time, required attendance and required assessments were to be identified. This did not occur consistently. <u>Conclusion</u> In summary, the Facility has policies to cover most provisions of the Settlement Agreement; adoption and localization of some State Office policies, and ensuring all requirements of provisions are addressed, should address nearly all provisions. Procedures for routine review and revision of policies are lacking. Procedures for identifying who needs to be trained and the kind of training to be provided, and for ensuring training has occurred, need to be formalized. 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 additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	<u>Audit Policy and Process</u> The Facility Recordkeeping Policy CMGMT-25 had not been revised. This policy required audits of five randomly selected records each month. The Facility did have a process in place to audit five randomly selected records each month. The Facility's data management department provided a list selected by computer of five individuals across the whole Facility. The process calls for the records clerk from another unit to audit the Active Record and Individual Notebook. The URC 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. 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. Five randomly selected records were audited each month since the last compliance visit.	Substantial Compliance

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		Audits were done of all charts in the Active Record and the Individual Notebook. In addition, the URC audited the D-list items in the Virtual folders on the Shared drive to check for agreement. 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 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. The Facility provided a listing dated 6/16/14 of deficiencies and which discipline was responsible . The Facility also provided graphs of timeliness of Functional Skill Assessments and communication skill acquisition plans (SAPs). 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 over the prior six months as evidence this was occurring. 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. This interview has been described in prior reports. The second process involved direct observation of IDT meetings and completion of a checklist of items to be observed. Regarding use of records in ISP annual planning meetings, information from these audits is found in Provision V4. <u>Interobserver Agreement/Interrater Reliability</u> As noted above, the URC and records clerk audit a record. For the three months of audits reviewed, nine (60%) were dated the same day, five (33%) were dated one day apart, and one (7%) was dated three 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 is acceptable and continues to improve across review periods. Per interview with the URC, these audits are conducted independently, without discussion prior to comparing the results. For each audit, the Facility enters the responses to each item on the Section V monitoring	

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		tool into a database, from which an item by item comparison sheet can be produced. This sheet not only has the specific ratings by each reviewer, it also calculates the percent agreement. (including items one or both reviewers marked N/A) . The Facility provided these sheets for five audits each month from February 2014 through May 2014. Agreement over this period ranged from 76% to 97%, with monthly averages of 84% for February, 88% for March, 86% for April, and 90% for May, and an overall average of 87% agreement. This is an acceptable agreement level. Monthly averages were slightly higher than in the last review period. The Facility also provided, in the May 2014 report to the QA/QI Council, a graph of monthly average agreement from May 2013 through April 2014. The data on the graph for February, March, and April 2014 matched the averages on the sheet. The graph showed stable and consistent agreement levels throughout the 12 months, with This acceptable level of agreement has continued for several review periods. Disagreements were in bold print on the sheets. This facilitated visual review to determine whether there were any patterns of items on which there was disagreement. Visual review by the Monitoring Team did not identify any patterns. In reviewing the last 15 audits, the Monitoring Team discovered an issue of concern. For the item, "Is there evidence of Falsification of records" all audits were rated N/A. The the monitoring tool provided "Possible signs of falsification" and stated, "If there is no falsification of records than (sic) write yes." The Monitoring Team brought this to the attention of the Facility and was informed that the URC and Records Clerks had shifted from the definition on the form to the practice of rating N/A. This brings into question whether reliability checks were truly independent. Although the process appeared independent, the discussions of definitions led to a shift that was not reflected in the definitions. That is unacceptable; rating should be done per the definitions in order to ensure that changes in data do not reflect shifts in rating rather than true changes in what has occurred. The Facility reported rating would again be based on the definition on the monitoring tool. The Facility did not report reliability data for the audit tools for the Active Record and Individual Notebook. In past reviews, the Facility showed the Monitoring Team audit information available on computer that shows agreement item by item on each audit, with data showing acceptable levels of agreement. <u>Audit Findings and Review of Trends</u> Five audits were completed each month in April, May, and June 2014 and were provided to the Monitoring Team. Trend data were provided to the QA/QI Council in the Data Analysis Report for 5/27/14	

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		on overall compliance percentages for the Section V Monitoring Tool and compliance for specific issues including having all components of the Unified Record, meeting Appendix D requirements, and whether records have the information needed to make decisions. This report included graphs of: • Overall Average compliance (per Facility report, this included sections of the Section V monitoring tool rating compliance with Appendix D requirements, requirements for use of the record in decision-making, and accuracy of recordkeeping), which was slightly lower than during prior review periods • Previous quarter by question (which covered compliance with items relevant to Provisions V1, V3, and V4—the recordkeeping provisions of Section V) • Facility record audit/D-list tool accuracy through April 2014, which had been variable since the last compliance visit but had returned to greater than 90% • Missing Current Document, which had a decreasing trend • Legibility, which showed improvement • Individual Notebooks Security, which had been stable at 85% or above since the last compliance visit • Data gaps, which had increased • Information from the Integrated ISP audits of ISP meeting observations on use of information from the records, which had begun to show improvement As reported in Section E, this report included analysis of the data in the graphs. It also listed accomplishments for the quarter, challenges, a summary analysis of the data, review of corrective action plans, and prioritized areas for the next quarter. This is a useful format that encourages use of the data for analysis of status and for planning improvement actions. The Facility had implemented a process for review of data by Residential Services management staff. The Facility provided the Residential Services Management Team (RSMT) Report with data through May 2014. This report includes several items relevant to recordkeeping. This process provides information that permits residential management staff to identify issues needing to be addressed. This addresses a recommendation the Monitoring Team has made in several reports—that responsibility and accountability for accurate recordkeeping should be assigned to the management staff who oversee those staff who document in records. Much of the information in the RSMT Report provided to the Monitoring Team was the same as in the report to the QA/QI Council. In addition, some of this information was broken down by unit or records clerk; this will be helpful in facilitating action by Residential Services management.	

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		Trends show some areas of improvement and some areas of decline. The Facility has taken some actions to address these, including the implementation of the RSMT report. Not enough time has passed to assess the effectiveness of these actions. Nonetheless, the information provided from the audits has led to actions intended to improve recordkeeping. <u>Corrective Actions</u> The Facility had a process to take corrective actions for specific deficiencies identified in audit of an individual record, to ensure corrective actions were completed, and to track deficiencies to determine trends that require systemic action. As reported by the URC and verified by review of audits, the process of correction began following the audit with the URC sending an email of the findings and corrective actions needed to the people responsible for the specific documents or to administrative staff responsible for actions requiring training or systemic improvements (such as improving legibility, which cannot be corrected on the document itself but should be improved on current and future documentation). A due date for responses of five business days was stated in the emails. For 15 of 15 audits reviewed (100%), documentation was provided that corrective actions were required for the deficiencies identified. The Facility reported that the next step in the process was for the URC to track findings sent for correction between five and 10 days after sending the required actions. The Facility maintained and provided for Monitoring Team review a DSSLC Monthly Audit Tracking database report and provided the report for July 2014. 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 monthly database sheets continue to be tracked until all corrections are made. For example, the June 2014 sheet had one item not corrected, with a notation that an email was sent in July. The Monitoring Team selected randomly by computer from audits done in August the record for Individual #527 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, the Observation Notes continued to have gaps at bottoms of pages. There was documentation of staff training on use of signature legends,	

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		but some still were not completed by all staff. There were gaps in data on the Flow Record for June 2014. <u>Additional Audits</u> In addition to the random audits required by this provision, the Facility conducted several other types of audits, including: • As reported in Provision V1, the Facility audited virtual folders in the Share Drive to determine whether certain specific documents were posted, such as assessments, monthly clinician progress notes, skill acquisition plans, and QIDP reviews. Records clerks review the virtual folders on Mondays to determine if any of these documents have not been entered as required and send out a list of those that need to be done. On Wednesdays, they check again and send a formal delinquency list. • Program auditors monitor records for certain specific documents and to gather quality assurance information. • A program auditor observes one ISP annual planning meeting per month and completes and integrated planning review. Two questions specifically ask about use of the records. Other questions ask about specific documents, such as the ISP. The program auditor reviews the records after the due date for these documents and assesses whether required documents are completed and filed timely. <u>Conclusion</u> This provision continues to be in substantial compliance with requirements. The audit system continued to be robust and comprehensive. At least five random audits were conducted each month. Reliability across auditors was adequate, although there arose a concern about independence of the reviews. Audit findings for individual records were sent to staff responsible for making corrections. The Facility has a system for tracking corrections that tracks deficiencies until there is evidence they have been corrected. Although all cleared items had been corrected for one individual sampled by the Monitoring Team, some Appendix D requirements continued not to be met in current documentation. 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 and completing initial legends, to determine whether they improve. The new RSMT data process holds promise for leading to such improvement, because it places responsibility on the residential managers to ensure continuing compliance. Further review will determine whether this has an affect. Although substantial compliance will be continued, two issues constitute a temporary failure to comply during a period of otherwise sustained compliance. The first of these is	

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		the shift of the definition of falsification that suggests that Interrater reliability monitoring is not entirely independent (although there was no evidence this was the case for any other definitions). The second is that, contrary to prior reporting periods, there was a decline in compliance with Appendix D requirements; however, the Facility has taken action to address the lack of improvement. Future compliance will be dependent on whether these two issues are addressed effectively.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The Monitors and the parties agreed to a list of actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at DSSLC. <u>Records are Accessible to Staff, Clinicians, and Others</u> As reported in Provision V1, 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 two of two individuals checked by the Monitoring Team in visits to apartments (100%), the Individual Notebook was readily accessible. For six of six individuals checked (100%), the Active Record was either present and readily accessible or had been checked out correctly. The Monitoring Team did not find concerns with lack of accessibility of records during this visit. <u>Documents are Filed in the Record Timely and Accurately</u> The Section V monitoring tool checked whether documents in the record were current. For the 15 audits conducted by the Facility in April, May, and June 2014, responses to that item on the reviewed audits showed three of 15 records (20%) were rated as Current. Audits of one record (Individual #744) by the Monitoring Team rated one (100%) Current. The Facility provided additional data on whether documents were missing from records. A graph with number of missing documents from February 2013 through April 2014 showed a decreasing trend, indicating fewer documents were missing. Of the 15 audits, two records (13%) were rated as complete. The record audited by the Monitoring Team was rated not complete. The Facility had implemented a process to audit whether ISPs were completed and filed in the Active Record timely. Audits by Records Clerks of records included checks of whether ISPs were completed within 30 days and were filed within 30 days. As reported in Provision F2f, ISPs had not been filed consistently within a 30-day period following the	Noncompliance

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		annual ISP meeting, which led to implementation of the new audit process. Although required assessments were, for the most part, completed at least 10 working days prior to the annual ISP planning meeting (although that could not be confirmed with confidence, as the ISP preparation meetings that were to establish the required assessments were not held consistently), this was not consistent across disciplines and assessments. As reported in Section F of this report: • In the sample of eight ISPs completed prior to the monitoring visit, none (0%) had all required assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. In several instances, some assessments were still not completed until after the meeting was held. • Overall for this sample, the rate of timeliness was 68%, which was slightly below the 73% at the time of the previous monitoring visit. As reported in Section M, the Monitoring Team's review of the 12 most recent completed admission, annual and quarterly assessments found they were completed timely greater than 85% of the time. An example of variability of assessment completion was provided in the RSMT report. Timeliness of Functional Skills Assessments campus wide showed a decreasing trend since October 2013. However, that was variable across apartments, with some showing consistently high percentages of timely completion and others showing low or variable percentages. <u>Data are documented/recorded timely on data and tracking sheets</u> For the most part, data were documented and reported timely. However, several errors were found in the samples reviewed: • As reported in Provision M6, review of the July 2014 MARs for individuals in Garden Ridge found several medications were neither initialed nor circled. • As reported in Provisions S1 and S3a, data for skill acquisition plans were not consistently entered; most skill acquisition programs in the sample reviewed had missing data. • As reported in Provision O7, aspiration trigger sheets contained multiple gaps in data, and triggers were not consistently documented on the trigger sheets when they occurred. <u>IPNs Indicate The Use Of The Record In Making These Decisions (Not Only That There Are Entries Made)</u> 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	

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		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 five or more disciplines (note that specialty nurses such as the Skin Integrity Nurse counted as separate disciplines). The self-assessment reported that this occurred for 21 of 25 records (84%). Of 15 audits provided by the Facility for the months of April, May, and June 2014, 11 audits (73%) reported entries by more than five disciplines; this compared to 93% reported in the audits for the last compliance visit. Nonetheless, all included at least medical and nursing disciplines, and most included at least some other clinical disciplines such as speech/language pathologist, Dental, and psychologist. <u>Staff surveyed/interviewed indicate how the unified record is used</u> The Facility reported in the Self-assessment that it conducted interviews using the Interview Tool for use of the Record The Self-assessment reported that 19 of 20 interviews (95%) indicated staff made use of the records to make decisions on care, treatment, and training. 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. Nonetheless, as indicated below, observation at meetings found use of the record was variable. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> A program auditor used an extensive ISP monitoring checklist to assess a wide range of issues, one of which was use of the record at meetings. Reliability observations across auditors have begun. These data were 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. Per interview, four such monitorings were done each month, with the intent of doing one per QIDP at least once every six months. According to the self-assessment and a data report provided by the Facility, data and information in the record were available and utilized in making decisions during 70.4% of meeting discussions, with a monthly range from 41.7% to 83.3% (an increase compared to 61.8% reported for the last compliance visit period). The Monitoring Team observed ISP annual planning meetings for Individuals #280 and #638. At the meeting for Individual #280, the record was present, but the IDT did not refer to it for information. All disciplines referred to documents they had with them. IDT members did provide clinical data.	

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		At the meeting for Individual #638, records were present. As with the ISP meeting for Individual #280, the records were not referenced. The QIDP brought a copy of each assessment. The Monitoring Team observed an ISP Preparation meeting for Individual #235. Records were present. The nurse opened the record to look up information. The PNMP was referenced. The nurse also provided information from an ISP addendum and the individual's weight. The nurse gave a summary of data on frequency of scratching. The QIDP stated the individual had one fall; the nurse stated she tried to get information from Avatar but she got too many pages to review. Although the data on falls might or might not have been accurate, the meeting participants did make good use of data during its deliberations and planning at this meeting. The Monitoring Team observed a Change of Status meeting for Individual #684. The Monitoring Team did not observe that the Active Record was present. The IDT was unable to clearly answer questions regarding past review or past diagnostics. This would have been possible if the record was present. <u>Conclusion</u> This provision is not yet in substantial compliance. Records were generally accessible. Some problems were identified in entering data and information timely. Timeliness of assessments so they are useable in preparing for ISP planning needs further improvement. The Facility's data and Monitoring Team observations of meetings showed improvement in presence and use of records but still some inconsistency, indicating a continuing need to improve use of the records at meetings for decision making.	

List of Acronyms

Denton State Supported Living Center
July 21-15, 2014, Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADAMS	Anxiety Depression and Mood Scale
ADHD	Attention Deficit Hyperactivity Disorder
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
BSPPS	Behavioral Support Program for Psychiatric Symptoms

BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
CBC	Criminal Background Check or Complete Blood Count
CDC	Centers for Disease Control and Prevention
C-Diff	Clostridium Difficile
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
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
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
HST	Health Support Team
HT	Habilitation Therapy
IBHA	Integrated Behavioral Health Assessment
IBW	Ideal Body Weight
IC	Infection Control/Informed Consent
ICF	Infection Control Form
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
IMM	Incident Management Meeting
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
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
NSI	Non-serious Injury Investigation
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
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
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
SPA	Speech Pathology Assistant
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