# United States v. State of Texas

## Monitoring Team Report

## Denton State Supported Living Center
## March 29-April 2, 2010

**Date of Report: June 28, 2010**

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## Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three (3) Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him/her every six (6) months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of Denton State Supported Living Center (DSSLC).

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.

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 SA.

## II. 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 March 29-April 2, 2010, the Monitoring Team visited Denton 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. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

## III. 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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **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;
(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;
(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;
(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, 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 SA.

## IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Denton State Supported Living Center (DSSLC) for their welcoming and open approach to the first monitoring visit. It was clear that the State's leadership staff and attorneys as well as the management team at DSSLC had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. This was much appreciated, and set the groundwork for an ongoing collaborative relationship between DSSLC and the Monitor's Office.

The baseline tour provided an opportunity to become familiar with the policies, procedures, processes, and structure of DSSLC. Team members used this time to meet and discuss with a wide range of facility staff to provide an understanding of structure and services, and to develop a collaborative approach to the review and improvement process. The team examined a great deal of documentation and carried out many observations and interviews in order to evaluate the status of the facility practices. The report describes status of provisions but does not provide decisions about compliance with provisions; that will begin at the first compliance review.

**Positive Practices**
It is clear that DSSLC is making significant efforts to improve services and meet many of the provisions of the Settlement Agreement. The monitoring team would like to recognize some positive practices and improvements. This is not an exhaustive list. Reviewing the assessments of provisions will reveal additional positive practices, and there are certainly others not mentioned in this review.

Use of Restraint. Restraint use is trending downward. The Facility policy on Dental/Medical Sedation is comprehensive and can serve as a good basis for improving practice.

Integrated Planning. Psychiatry and psychology have developed a working relationship that can be the basis for improving assessment and treatment.

Psychology. DSSLC employs four psychologists who are credentialed as Behavior Analysts. These staff displayed a well-developed set of professional skills and expertise. The Psychology Department has developed a sound internal peer review process.

Nursing . Annual and quarterly nursing assessments are done timely and contain comprehensive information.

Habilitation. The on-campus and community work sites were well organized, goal oriented, and presented a variety of vocational choices to the individuals employed there. As a result, individuals were successful at their chosen tasks and were not observed to rely upon undesired behavior to meet personal needs.

Most Integrated Setting. The Facility has a number of promising elements in place for a comprehensive approach to planning and facilitating transition and discharge to the community, most notably several enthusiastic and creative individuals in key management positions. Qualified Mental Retardation Professionals (QMRP)s and Personal Support Teams (PSTs) have received some training and there has been a noticeable change in the community living content of the Personal Support Plans (PSPs) over the past year.

**Status and Specific Findings**

Use of Restraint
Use of restraint for non-medical purposes is trending downward. DSSLC policy on restraint use is comprehensive; however, there are implementation issues as noted in this report. This suggests that the facility would benefit from additional training, job coaching, and quality assurance (QA)activity.

The facility policy on Dental/Medical Sedation is comprehensive, including a considerable amount of information on strategies to eliminate and minimize the need for dental pre-treatment sedation/restraint. Psychiatrists are not involved in the process of evaluating individuals referred for pre-treatment sedation.

Abuse, Neglect, and Incident Management
Staff interviewed all understood the facility's zero tolerance policy on abuse and neglect and all knew how to report allegations. The system for the investigation process was, for the most part, well organized and well understood by those responsible for its implementation. Staff in this area appeared knowledgeable and well trained.

Quality Assurance

DSSLC has a QA policy that needs refinement to more specifically address QA activity at DSSLC. The current policy is largely a restatement of the State policy. The facility engages in a great deal of QA monitoring resulting in many reports that ostensibly provide insight into performance in a number of subject areas. There is some question as to if the staff using the monitoring tools are sufficiently trained in knowing what to look for and how to assess a given data item. Some QA reports show a high degree of compliance that was not evident to the monitoring team during observation in the course of the review (e.g., certain elements in the meal monitoring tool).

Integrated Treatment, Services, Protections, and Supports

The current PSP process meets some of the technical requirements of the Settlement Agreement (SA) however most of the elements required in Section F were either not developed or not thoroughly implemented, making substantive baseline assessment difficult. The monitoring team is aware this format, and accompanying instructions, are subject to a significant modification and that a statewide workgroup is being convened to develop a PSP policy that will refine the PSP process in a manner intended to facilitate compliance with the SA.

Overall, through document review, interview, and meeting observation there was little evidence of departments and disciplines coming together throughout the year, and in anticipation of the annual PSP planning process, to assess individual needs and develop service strategies in an integrated manner.

Integrated Clinical Services

Although examples of integrated planning and review exist, there are many opportunities to improve integration. The PSP process needs to be revised; PSP meetings consisted largely of individual team members reading or summarizing reports.

Minimum Common Elements of Clinical Care

Provision of clinical services is variable across disciplines. Some aspects of clinical services meet current, generally accepted professional standards of care. Other aspects do not yet meet these standards. Improvements are needed in assessment, identification and use of indicators of efficacy, and monitoring of care.

Assessment of Risk

Throughout the report are indications that assessment of risk is not consistent with clinical need and does not adequately trigger a risk-based frequency of assessments. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. As a result, intervention may not be timely if an individual's health or behavioral risk changes. Therefore, DSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk.

Psychiatric Services

The psychiatry program at DSSLC appeared to be strong in both clinical substance and process. A continued focus on overall interdisciplinary integration is advised, and attention to several specific areas is warranted, to assure compliance with SA requirements.

Staff psychiatrists had appropriate training and credentials. Psychiatrists worked with colleagues from medicine and psychology in a collegial and respectful manner. DSSLC psychiatrists received strong support from other professional services. Pharmacy support was provided through day to day communication, through participation by pharmacists in healthcare team meetings, and through comprehensive QDDRs. DSSLC nurses were engaged meaningfully in the day-to-day behavioral health care.

Nevertheless, the need for continued improvement was evident in a number of areas. Some diagnoses lacked clarity regarding the grounds upon which they were selected. Psychiatrists were not involved in evaluating individuals regarding pre-treatment sedation. Case formulation for the purpose of pharmacotherapy remained, however, largely in the hands of psychiatry rather than integrated with other interventions through combined assessment and case formulation. Psychotropic medication plans did not articulate details about how treatment efficacy will be determined.

Psychological Services

DSSLC employs some psychologists who are Board Certified Behavior Analysts as well as psychologists who do not have that credential. There was a substantial difference between the two groups in the ability to conduct behavior assessments and develop sound behavior interventions. The staff members without the BCBA were less likely to have conducted a functional assessment of undesired behavior conforming to current accepted practices. This group was also more likely to have developed PBSPs that lacked the correct use of terminology, did not apply behavior change principles correctly, and did not reflect an empirical, evidence-based approach to treatment.

Regardless of whether a staff member possessed the BCBA or not, psychologists at DSSLC often did not conduct a thorough or timely assessment of mental illness, medical conditions, or physical issues in relation to undesired behavior. Similarly, psychological assessments commonly reported scores for adaptive behavior or intellectual assessments that were many years old.

Competence in applying behavioral principles is lacking in staff members outside of the Psychology Department. As a result, numerous undesired behaviors continue without intervention or are inadvertently strengthened by inappropriate interventions

Substantial limitations are apparent in efforts by DSSLC to document and monitor behavioral interventions. Data collection procedures lack individualization and sophistication. There is no system in place to review interobserver agreement or determine the accuracy of behavioral data.

Medical Services

Routine medical services were provided to the individuals who live at DSSLC in settings that were determined by clinical need. . Medical rounds were conducted on a daily basis. To promote interdisciplinary communication, physicians led quarterly HST meetings. The medical staff met on a regular basis, and there was medical representation on many DSSLC oversight committees. There was an internal 24 hour physician on-call system.

Nursing

Because of vacancies, nurses from agencies provide some coverage. Recruiting for additional nurses is ongoing. The Nursing department had developed a few monitoring tools and was in the process of developing additional tools. An internal Peer Review System would serve to improve quality of services and enhance skills and practices of nurses. DSSLC's Nursing department has recently developed and implemented numerous nursing policies, procedures and protocols, as listed in the above documents. They were thoroughly reviewed and found to be in alignment with the current acceptable professional standards of nursing practice defined in the Settlement Agreement (SA) and Health Care Guidelines (HCG), although nursing management staff did not have a clear understanding of the SA and HCG requirements. Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar. Sections listing lab values and diagnostic tests, consults, and system reviews usually provided comprehensive and detailed information. Review of Medication Administration Records (MARs) identified numerous "holes" for some of the prescribed medications without circles or explanation as to why medications were not initialed. Accountability Sheets contained in each MAR use to assist in preventing medication error were not consistently completed.

Pharmacy

DSSLC provides a pharmacy. The pharmacy established procedures for safe medication practices to assure that a pharmacist will review newly prescribed medications and will review with physician and other providers any potential interactions or contraindications to the use of those medications. Pharmacists provided ongoing communication with clinicians about possible drug/drug interactions prior to and throughout the course of medication administration.

Quarterly Drug reviews were conducted according to policy. When indicated, recommendations were sent to the prescribing physician to accept or reject. Pharmacists participate in Health Status Team (HST) meetings.

Physical and Nutritional Management

DSSLC has a great deal of work to do to ensure safe dining and safe practices at other times that involve swallowing, such as medication passing and oral care. While most individuals have a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene, medication administration, behavioral information, and signs and symptoms associated with aspiration or decline not being included as part of the document. Individuals who are at a "high risk" are not being identified and therefore may not be receiving the care and treatment required to prevent future illness. Additionally, the assessment process involved in the development of the PNMPs includes little input being provided by therapy regarding positioning for GERD management, oral hygiene techniques, water safety and presentation of medications.

Staff were not observed referring to dining cards or PNMPs. Monitoring of dining plans is done primarily by staff who do not have specialized training or expertise in swallowing disorders and physical and nutritional management practices.

Physical and Occupational Therapy

Currently, DSSLC has eight full time Occupational Therapists (OT), seven Occupational Therapy Assistants, and five full time Physical Therapists (PT). DSSLC has listed three full time PT positions but as of this review, the positions have not been filled.

Habilitation Therapies have and continue to provide assessments; however, clear expectations regarding the frequency and depth of the assessments was missing. While the assessments contained information relevant to areas of functional mobility and adaptive positioning equipment, they were lacking in detail contained in the Health Care Guidelines.

Individuals who have plans in place (positioning, alternative positioning, and/or mealtime) are not consistently provided with supports, and there is not an effective monitoring system in place that provides reliable data and tracking.

Dental

DSSLC had an onsite dental clinic that was well staffed. The dental clinic has a computerized system for scheduling appoints and collecting data. It was unclear how refused and missed appoints were rescheduled or follow-up. Although the Dental Clinic maintains a computerized appointment schedule, review of the records failed to provide clear information regarding individuals who refused or who missed appointments flow back to their respective qualified mental retardation professional (QMRP).

Review of dental records and PSPs failed to include specific recommendations for desensitization for individuals identified as needing some form of dental sedation, and the process to develop such a program and get consent from an LAR is not timely.

Communication
The majority of individuals have not been provided with a comprehensive speech and language assessment. As of this review, approximately 100 individuals have been assessed to determine if they would benefit from an assistive communication device.

DSSLC has only 2.5 Speech positions at this time resulting in difficulty performing assessments in a timely manner and difficulty maintaining an appropriate speech system. Due to the limited number of Speech Therapists, active participation in the team process (participation in meetings, monitoring. and development of goals) is not occurring in a timely and comprehensive manner.

Habilitation, Training, and Skill Acquisition
Record review, observations and staff interviews reflect a process of teaching that is substantially lacking in the components necessary to produce, maintain or strengthen individual skills. Skill assessments lack rigor. Formal teaching plans do not conform to the standards of applied behavior analysis and lack the components necessary to effectively strengthen behaviors.

The on-campus work sites were well organized, goal oriented and presented a variety of vocational choices to the individuals employed there. As a result, individuals were successful at their chosen tasks and were not observed to rely upon undesired behavior to meet personal needs. The early stages of supported employment have been initiated. Observations in residences did not often reveal ongoing engagement or teaching.

Planning for Movement, Transition, and Discharge
DSSLC has reported only eleven individuals moving to the community since July, 2009, and one of those returned within a week. This rate, approximately 1.8% of its population, is on the low end of other SSLCs that have a census of over 400.

The Facility does have a number of promising elements in place for a comprehensive approach to planning and facilitating transition and discharge to the community, most notably several enthusiastic and creative individuals in key management positions.

Much more training in the fundamentals of person-directed planning and in the implementation of the Settlement Agreement requirements is needed. DSSLC has some in the planning stages.

The Facility has many good ideas for creating awareness of community living options. Many of these are in the idea phase. It will be important for all of these ideas and strategies to be coordinated in a comprehensive plan. DSSLC and the Contract Mental Retardation Authority (MRA) appeared to have formed a close working relationship that includes interacting regularly on an informal basis, holding regular joint meetings, and working together to design and implement some innovative approaches

There remains a good deal of work to be done to build the community system of supports and services

Guardianship and Consents
DSSLC does not have a clearly defined policy or process for assessing an individual's need for a Legally Authorized Representative (LAR), nor for prioritizing that need, although there has been some work done on developing a methodology for the latter. Most people who live at the Facility have an LAR.

Recordkeeping

DADS is in process of revising the policy for recordkeeping. DSSLC follows the current DADS policy and has established a Facility policy that adds local procedures.

DSSLC reviews a sample of records for quality. The review includes questions that check items that go beyond the records themselves. Specific items are reported on. The monitoring team did not determine how this information is used for corrective actions or trending.

Use of records in decision-making is variable. Records were not referred to during PSP meetings, but a record was used to resolve a question during an HRC meeting.

In Summary

The above comments summarize the details presented in the full report. Although the challenges presented may seem overwhelming, the monitoring team encourages DSSLC to meet those challenges. DSSLC is making significant efforts, with the support of the state of Texas, to improve services. Making these improvements is a long-term process. The monitoring team is optimistic that this process can go forward effectively.

## Status of Compliance with the Settlement Agreement

| **SECTION C: Protection from Harm-Restraints** | |
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| Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DADS Policy #001: Use of Restraint, dated 8/31/09<br>2. DADS Policy #006: At Risk Individuals<br>3. DSSLC Policy # CMGMT-14 At Risk Individuals<br>4. DSSLC Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09<br>5. DSSLC Policy CMGT-03B Drugs For Behavior Intervention dated 4/1/07<br>6. DSSLC Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09<br>7. PMAB Training Curriculum<br>8. PMAB Staff Training Logs 12/09 and 1/10<br>9. Emergency Use of Psychoactive Medication Checklist for Individual #359 (1/9/10)<br>10. Restraint Checklist and Debriefing Form for Individual #411 (3/2/10) and Emergency Use of Psychoactive Medication Checklist for Individual #359 (1/9/10)<br>11. Restraint Checklist and Debriefing Form for Individual's #411 (3/25/10), #537 (3/19/10 and 3/25/10), #381 (3/25/10), and #337 (3/25/10).<br>12. PBSP and Safety Plan for individuals #337, # 381, #537, and #269.<br>13. Restraint Checklist for Individual #386 (3/24/10).<br>14. Facility restraint log 7/09 to 2/10<br>15. List of employees injured and requiring medical attention resulting from restraint application (7/09 to 1/10).<br>16. List of individuals injured during restraint (7/09 to 2/10).<br>17. Facility restraint log for medical restraint (7/09 to 2/10)<br>18. Facility restraint log for nonmedical restraints (7/09 to 2/10)<br>19. Facility Restraint Analysis report for July-September 2009.<br>20. Facility Restraint QA reports for November, 2009 through March, 2010.<br>21. PSP's for Individuals #50, #374, and #624.<br>22. PSP Addendums for Individuals #50, #374, and #624.<br>23. HRC minutes from 2/24/10, 2/25/10, 3/5/10, 3/11/10, 3/18/10, and 3/24/10.<br>24. FY10 Trend Analysis 12/1/09 to 2/28/10<br><br>**People Interviewed:**<br>1. Rebecca Wilkins, Director of Quality Assurance<br>2. Frank Padia, Director of Program Coordination<br>3. Deb Salsman, Director of Incident Management<br>4. Tammy Hampton, Incident Manager<br>5. Randy Spence, Director of Behavioral Services<br>6. Elaine Davis. Director of Training and Development<br>7. Six Direct Care Professionals (DCPs) |

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| | 8. Nine individuals served #79, #231, #327, #337, #381, #386, #545, #624, and #727.<br><br>**Meetings Attended/Observations:**<br><br>1. Incident Management Team 3/29/10.<br>2. Health Status Team for 526C 3/30/10<br>3. Annual PSP for Individual # 327 3/31/10<br>4. HRC 3/31/10<br>5. Critical Incident team meeting 3/31/10<br>6. QMRP meeting 4/2/10<br>7. Living Area Observations: 513B, 515D, 528A, 528B, 528D, 504B |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:** Restraint use at DSSLC is trending downward. In FY2009 restraint use averaged 30 per month. In the first half of FY2010 this was reduced to an average of 18 per month. Facility leadership would be well served to examine what they believe are reasons for this significant reduction to facilitate organizational learning and development.<br><br>DSSLC policy on restraint use is comprehensive; however, there are implementation issues as noted in this report. This suggests that the facility would benefit from additional training, job coaching, and QA activity.<br><br>The facility policy on Dental/Medical Sedation is comprehensive, including a considerable amount of information on strategies to eliminate and minimize the need for dental pre-treatment sedation/restraint.<br><br>Safety Plans that accompany Behavior Support Plans are for the most part easy to follow; however, it is unclear if staff fully understands them. Ongoing onsite monitoring and training may be of benefit.<br><br>The system for restraint use at DSSLC is, for the most part, well organized and understandable. A noticeable exception is the apparent lack of specific protocol and work activities designed to comply with the SA requirements associated with individuals who are restrained more than three times in any rolling 30 day period. |

| # | Provision | Assessment of Status | Compliance |
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| C1 | Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate | DADS Policy 001 – Use of Restraints prohibits the use of prone restraint. This policy also addresses the other elements required by the Settlement Agreement (SA).<br><br>DSSLC Policy CMGMT-20, Limitation of Restraint as a Crisis Intervention prohibits use of prone restraint (Section 3-E). It also addresses the other elements required by the SA.<br><br>Section 3.A.1 limits the use of restraint to crisis intervention if an individual poses an | |

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| | and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used. | immediate and serious risk of harm to him/herself or others.<br><br>Section 3.A.2 requires that a graduated range of less restrictive measures be exhausted or considered in a clinically justifiable manner.<br><br>Section 3.A.4 requires that the use of restraint not be used for punishment, convenience of staff, or in the absence of or an alternative to treatment.<br><br>Section 3.A.5 requires restraint use to be governed by written policies, procedures, and plans.<br><br>From record review a number of implementation issues were identified which are described in sections C2, C4, C5, and C6 of this report.<br><br>DSSLC closely monitored data about the use of restraints. The manner in which the behavioral healthcare team was deployed to reduce the use of restraints was not clear. It was not clear whether psychiatrists were deployed to explore possible antecedents or precipitating factors, including medical reasons, for individuals who required frequent use of restraint. The development and adequacy of Positive Behavior Support Plans (PBSPs) is variable, with some use of functional assessment, but PBSPs are not uniformly effective, and the data gathered do not provide good evidence of efficacy. Therefore, restraints may be used in the absence of effective treatment. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others. | DADS policy SectionII.I.1 states "the individual must be released from restraint as soon as he or she no longer poses an immediate and serious risk of harm to him/herself or others. If there is a Safety Plan, the individual will be released according to the instructions that are stated in the Safety Plan (indicators when the individual no longer poses an immediate and serious risk of harm)."<br><br>DSSLC Policy CMGMT-20 Section 6 contains a similar requirement; however, a review of Safety Plans suggests that behaviorally stated release criteria, related to the individual no longer posing an immediate and serious risk of harm, are problematic, as indicated in examples below. The release codes typically used on the Restraint Checklist are also indicative of the lack of behaviorally based release criteria.<br><br>From document review the criteria for release from restraint are unclear. The Safety Plan for Individuals #381 and #337 did not contain clear language as to release criteria. For both individuals the release code on the Restraint Checklist indicated "met safety plan definition of calm" although no safety plan definition of calm could be found. The term "calm" is often inadequate when describing behavioral conditions that should dictate restraint release. A person may very well not be calm (e.g. yelling, crying, swearing) but is not in their present state a danger to him/herself or others. Restraint Checklists for most | |

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| | | records (e.g. Individual #411 and Individual #537) reviewed typically were coded for release using the "quiet/calm" code.<br><br>The restraint checklist for individuals #337 and #381 revealed additional issues. Under the item "describe events leading to behavior that resulted in restraint, " the description was inadequate. The checklist for individual # 337 had one word, "privacy"; the checklist for individual #381had one word, "bedtime." Neither is descriptive. Under the item "interventions attempted to avoid restraint" one indicated "SPCI" and the other "followed SPCI." Neither is descriptive and it seems unlikely that every strategy described in the Safety Plan was followed for these two very frequently restrained individuals. At the very least whatever was attempted is not recorded on the Restraint Checklist.<br><br>The Safety Plan for Individual #337 states "#337's behavior is an immediate and serious risk of harm to himself when: 1) he is in bed, and, 2) he is in his room alone." This is not descriptive of conditions that place the individual at immediate and serious risk of harm to himself or others. | |
| C3 | Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint. | DSSLC Policy CMGMT-20 and 21 govern the use of restraints. CMGMT-20 addresses crisis intervention, and CMGMT-21 addresses medical sedation and restraint.<br><br>CMGMT-20:<br>Section 4.B generally limits approved restraints to that which is described in the statewide PMAB manual.<br><br>Section 1.A .4 requires that restraint be applied in the safest, least restrictive, most humane, and most respectful way.<br><br>Section 2.C requires that before working with individuals staff must complete competency training on prevention and de-escalation strategies, restraint techniques and use, and supervision of individuals in restraint.<br><br>Section 11 provides additional requirements associated with restraint training including a requirement that the staff person demonstrate competency.<br><br>DSSLC's method to comply with this policy is to use the state PMAB training. This training curriculum includes elements that, if carried out in practice, should facilitate compliance with the SA. In reviewing a limited sample of logs of PMAB training attendance, and a sample of individual staff training records, staff are receiving this training. A larger sample will be required in future reviews.<br><br>Policy might be strengthened by clearly stating "successful completion" of the training and | |

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| | | further elaboration on how demonstrating competency is achieved. For people who require frequent and intense restraint (basket hold, mechanical or 30 minute sidelying), it is advisable to ensure staff who regularly work with that person get very specific training with respect to that person's specific behavior and restraint techniques and can demonstrate how restraint is to be performed, and, if it is likely for restraint application to occur in multiple environments where different conditions exist (e.g., few staff present) staff should problem solve this before an episode occurs or in the context of a debriefing process.<br><br>CMGMT-21:<br>This policy contains considerable detail with respect to procedures associated with dental/medical sedation and restraint. It includes requirements associated with the Restraint Checklist, health care provider roles and responsibilities, monitoring and care (both on and off campus), and strategies to minimize or eliminate the need for medical/dental restraint, including an attachment that describes 13 specific steps that can be taken by the Personal Support Team and home staff in this regard. Implementation of this policy will need to be tested in future reviews. | |
| 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. | DSSLC Policy CMGMT-20 Section 3.A.1 limits the use of restraint to crisis intervention. Other parts of Section 3 describe prohibited practices but the language is not clear and specific to the SA agreement requirement regarding "prohibited by the individuals medical orders or ISP." Data shows the DSSLC has a history of frequent restraint use. In FY2009 the Restraint Trend Analysis indicates restraint use 30 times a month. In the first six months of FY10 this has decreased to 18 a month. Further reviews will need to determine if the rate continues to decline, and, to ensure use of restraint is limited to crisis intervention.<br><br>As discussed in C3 DSSLC has policy direction with respect to medical restraints routinely used for medical or dental care. From a limited review of PSPs and from PSP meetings observed there was little indication this policy was addressed.<br><br>DSSLC does not always follow the policy of limiting restraint use to crisis intervention. The Emergency Use of Psychoactive Medication Checklist for Individual #359, under the heading "briefly describe the reasons for emergency psychoactive medication" the entry is "for sleep." Under the heading "description of dangerous behavior," the checklist entry is "not sleeping. " Neither suggests a condition that would require crisis intervention. | |
| C5 | Commencing immediately and with full implementation within six months, staff trained in the | DSSLC Policy CMGMT-20 Section 5.G requires that a restraint monitor conduct a face to face assessment of the individual as soon as possible but no later than 15 minutes after the start of the restraint to review the application and consequences of the restraint. | |

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| | 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. | Section 5.H.2 requires that a licensed health care professional monitor and document vital signs and mental status at least every 30 minutes. Section 5.H.3 extends this requirement to restraints which occur away from the facility.<br><br>From a limited record review it appears that DSSLC does not always comply with these policy requirements. In what was presented as the most recent use of chemical restraint (Individual #359 – 1/9/10) the Emergency Use of Psychoactive Medication Checklist indicates the restraint monitor was not notified at all.<br><br>Individual #537 was in a basket hold/horizontal restraint for 10 or 14 minutes (3/19/10). The information on the Restraint Checklist is contradictory. The Restraint Checklist does not identify, as required on the form, the specific location where restraint occurred. The Restraint Checklist codes release at 7:30 although in the "time released" section it states 7:34. There is no indication of post-release evaluation by a licensed healthcare professional. There is also confusing information on the accompanying debriefing; for example, the form indicates that medications were given in the time period prescribed (if in restraint at med pass), and that a meal was offered as near to mealtime as possible (if in restraint at meal time). The restraint was initiated at 7:20am and terminated either at 7:30 or 7:34. It seems unlikely that during this narrow timeframe both a meal and med pass were scheduled.<br><br>Increased training and oversight of restraint use and documentation is needed. | |
| C6 | Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is | DSSLC Policy CMGMT-20 Section 5.B contains requirements associated with each element of this section of the SA.<br><br>As noted in section C5, there is no documentation on the Restraint Checklist that Individual #537 received a post-release evaluation for injury. Individual #359 (chemical restraint) received one evaluation, exactly 30 minutes after receiving the restraint. It is unclear if the expectation for monitoring the use of chemical restraint was expected to occur at regular intervals, and, if so, what those intervals were to be or where this information would be documented. | |

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| | 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 the limited review of restraint records most individuals received 1:1 supervision while in restraint. Notable exceptions are Individuals #337 and #381. Both received routine supervision. This alternative level of supervision may have been specifically authorized by the Facility Director; however, authorization for an alternative level of supervision was not noted in the Safety Plan, and therefore this important information would not be immediately accessible to staff initiating restraint procedures. | |
| 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: | DSSLC Policy CMGMT-20, which looks to be the Facility's major policy governing use of restraints, addresses this element of the Settlement Agreement. In Section 7.2.c. however there is little evidence this policy requirement is being followed. The monitor identified three individuals (#50, #374, and #624) who met the 4+/30 day criteria. The monitoring team was told that the information to document the activity reflected in the SA would be in a PSP Addendum. In a document request the monitoring team asked for the PSP Addendums that reflected review per the SA. The information provided was insufficient to allow the monitoring team to assess compliance with a-g below.<br><br>DSSLC needs to develop specific protocol to guide QMRP's, psychology staff, and others in the work activities necessary to comply with this element of the SA. | |
| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |
| | (b) review possibly contributing environmental conditions; | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |
| | (c) review or perform structural assessments of the behavior provoking restraints; | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |
| | (d) review or perform functional assessments of the behavior provoking restraints; | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |
| | (e) develop (if one does not exist) and implement a PBSP based on that individual's particular | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |

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| | 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; | | |
| | (f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |
| | (g) as necessary, assess and revise the PBSP. | PSPs addendums did not contain sufficient information to determine if this work process occurred. | |
| 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 | CMGMT-20 Section 7.B.1 requires that each use of restraint used as crisis intervention that is not authorized by a Safety Plan be reviewed within one working day of the restraint and documentation of this review is in a PSP Addendum. In a limited review of three restraints this documentation was found in PSP Addendums.<br><br>Section 7.B.2 requires each episode of restraint, other than medical/dental restraint, to be reviewed within three business days at the Unit Meeting and the Incident Management Team (IMT) meeting. Through observation of the IMT meeting, restraint review is part of the regular agenda. Based on issues like those discussed in Section C-5 it would appear | |

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| | appropriate. | reviews need to be more thorough. | |

**Recommendations:**
1. Continue to develop and implement strategies that reduce the frequency of restraint use.
2 Refine, and or, increase restraint-related training and quality assurance activity related to procedures for restraint, documentation of restraint, definition and implementation of criteria for release to meet the requirements of the SA, and monitoring and documentation of vital signs.
3. Develop protocol and work activities to address settlement agreement requirements associated with individuals requiring restraint more than three times in a 30 day period.
4. Improve restraint review process and the accuracy of associated documentation such as the Restraint Checklist and Debriefing.

| **SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management** | |
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| Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DADS Policy #002.1 Protection From Harm – Abuse, Neglect, and Incident Management, dated 11/06/09<br>2. DADS Policy #001 Use of Restraint dated 8/31/09<br>3. Healthcare Guidelines, dated May 2009<br>4. Denton Policy CMGMT-01A-2009 Protection from Harm – Abuse, Neglect, and Incident Management, dated 2/24/10<br>5. Denton Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09<br>6. Denton Policy CMGT-03B Drugs For Behavior Intervention dated 4/1/07<br>7. Denton Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09<br>8. Denton Policy MED-06 dated July 2006 – Life Threatening Emergency Situations<br>9. Denton Policy Client Management-28 dated 2/23/10 – Guidelines for Staff Interaction with Individuals<br>10. Denton Policy General-13 – Volunteers, dated 2/18/10.<br>11. Volunteer records<br>12. Volunteer training curriculum<br>13. Denton Policy Client Management-01B Injuries to Persons Served in Residential Programs, dated 2/27/09<br>14. Denton Policy Client Management-01C Reporting, Documenting, and Review of Unusual Incidents, dated 6/8/09<br>15. Denton Policy Client Management-07 Absence Accountability, dated 5/11/06<br>16. PMAB Training Curriculum<br>17. PMAB Staff Training Logs 12/09 and 1/10<br>18. List of employees injured and requiring medical attention resulting from restraint application (J).<br>19. List of individuals injured during restraint (July, 2009-February, 2010)<br>20. Facility Restraint QA reports for November 09 through March 2010.<br>21. HRC minutes from 2/24/10, 2/25/10, 3/5/10, 3/11/10, 3/18/10, and 3/24/10.<br>22. FY10 Restraints Trend Analysis 12/1/09 to 2/28/10<br>23. Restraint, Incident,, and Injury Log for 528D<br>24. Incident Management Review Team Meeting Notes/Logs for 3/15/10, 3/22/10, 3/24/10, 3/25/10 and 3/29/10.<br>25. Individual Training Records for Facility Investigators<br>26. Personnel documentation for MW<br>27. Abuse and Neglect Allegations log 7/1/09 to 3/26/10<br>28. Peer Caused Injury log 7/1/09 to 3/30/10<br>29. Injury Summary (by individual) 7/1/09 to 3/29/10 |

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| | 30. Top 10 Aggressors (Individuals who caused injuries to other individuals) 7/1/09 to 3/30/10<br>31. UIR's 10-032, 09-366, 10-149, 10-137, 10-005, 10-094, 10-125, 10-142, 10-064, 09-459, 10-128, and 10-130<br>32. Top 10 Injured Individuals 7/1/09 to 3/25/10<br>33. Home Shift Log 523A 3/17/10<br>34. Instructions for Completion of Unusual Incident Investigation Form<br>35. Investigation Review/Approval Form<br>36. DFPS Investigation Reports 34854772, 35233573, 35083050, 35571009, 35271029, 35154629, 33659970, and 31725829.<br><br>**People Interviewed:**<br>1. Rebecca Wilkins, Director of Quality Assurance<br>2. Frank Padia, Director of Program Coordination<br>3. Deb Salsman, Director of Incident Management<br>4. Tammy Hampton, Incident Manager<br>5. Randy Spence, Director of Behavioral Services<br>6. Elaine Davis. Director of Training and Development<br>7. Six Direct Support Professionals<br>8. Nine individuals served: #79, #231, #327, #381, #386, #545, #624, and #727.<br>9. Serena Knox, Facility Investigator<br>10. Ashley Frederick, Facility Investigator<br>11. Personnel Staff – Jerome Young, Donna Nelson, Jan Archer, and Sharon Godoy<br>12. Melissa Bradley, Volunteer Services Coordinator<br>13. Chloe Woodford, DFPS Investigator<br>14. Andy Maher, Director of Consumer and Family Relations<br>15. Nora Brookins, Incident Auditor<br>16. Charles Martin, Client Injury Specialist<br><br>**Meetings Attended/Observations:**<br>1. Incident Management Team 3/29/10.<br>2. Health Status Team for 526C 3/30/10<br>3. Annual PSP for Individual # 327 3/31/10<br>4. HRC 3/31/10<br>5. Critical Incident team meeting 3/31/10<br>6. QMRP meeting 4/2/10<br>7. Living Area Observations: 513B, 515D, 528A, 528B, 528D, 504B |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br><br>DSSLC Policy CMGMT-01A, Protection from Harm – Abuse, Neglect, and Incident Management appears to be the major policy in place to direct activity associated with this section of the Settlement Agreement. It |

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| | was last revised 2/24/10. Its 30 pages appear to contain most of the essential elements required in the Settlement Agreement. Many elements of this policy look like they were simply copied from the State policy. This sometimes makes reading and understanding the policy awkward. The facility would be well served by taking another look at this policy to ensure it is specific to DSSLC expectations and operational procedures.<br><br>Much of this review centered on the presence of an appropriate policy to support compliance with the SA. Some elements of implementation were probed but future reviews will need to focus more intensely on the effectiveness of implementation.<br><br>Staff interviewed all understood the facility's zero tolerance policy on abuse and neglect and all knew how to report allegations. The system for the investigation process was, for the most part, well organized and well understood by those responsible for its implementation. Staff in this area appeared knowledgeable and well trained.<br><br>There is a system in place for pre-employment and pre-volunteer background checks that, from the limited testing done, appears to be effective and timely.<br><br>Review of discovered non-serious injuries could be improved to ensure adequate investigation to rule out abuse or neglect occurs. |

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| D1 | Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals. | The DADS policy on abuse, neglect, and incident management was completed on November 6, 2009. The monitoring team reviewed the policy and it was found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding sections below.<br><br>The DADS abuse, neglect, and exploitation rules and incident management policy state that abuse, neglect, and exploitation are prohibited. SSLC's are required to comply with these State policies and rules.<br><br>DSSLC policies and procedures on abuse, neglect, and Incident Management also were reviewed. They are embedded in the Denton Policy CMGMT-01A: Protection from Harm – Abuse, Neglect, and Incident Management, dated 2/24/10.<br><br>The purpose statement at the front of Denton Policy CMGMT-01A does not state a prohibition against abuse, neglect, and exploitation (this is covered later in the policy on page eight). The statement labeled "Purpose" reads "any incident/situation which has harmed or may potentially harm a resident shall be immediately identified, reported, reviewed, investigated, and corrected." The purpose statement (or an upfront statement | |

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| | | of policy) should reflect the intent of the SA which is zero tolerance of abuse and neglect.<br><br>CMGMT-01A describes a comprehensive set of activities related to client protection including: staff training, protection for residents, notification responsibilities, prohibition against retaliatory action, temporary work reassignment of alleged perpetrators, the process for facility based investigations, the process for review and disposition of reports from the Department of Family and Protective Services (DFPS) and DADS Regulatory, incident management coordination, and data tracking, analysis, and corrective action.<br><br>Not included in CMGMT-01A is a process for the review of non-serious injuries for review or investigation to rule out abuse or neglect as a cause or contributory cause. A protection from harm policy should include an element that requires a review of discovered injuries or injuries of known cause (witnessed and where a probable cause hypothesis has been developed) to ensure reasonable and defensible judgments are being made as to the credibility of the person who witnessed the event leading to an injury, and/or, the credibility of the probable cause hypothesis. While the DSSLC has a process to address some aspects of this it should be reflected in the Center's major policy on Protection from Harm. It is important that non-serious injuries receive a level of investigatory scrutiny sufficient to allow a reasonable judgment that abuse or neglect was not a factor in the possible cause of the injury | |
| D2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require: | DSSLC Policy CMGMT-01A Protection from Harm – Abuse, Neglect and Incident Management includes provisions that cover most elements of the Settlement Agreement. Through documentation review, interviews, and observations a number of issues were identified. These are described in sections a-i below | |
| | (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 | CMGMT-01A Section V.A requires immediate (and in no case more than one hour after suspicion or after learning of the incident) notification to DFPS of any suspected act of abuse, neglect, or exploitation. This policy also requires immediate notification of the Facility Director, or designee, in order to begin the process of implementing client protection measures, securing evidence where appropriate, beginning an investigation and any other administrative actions deemed appropriate to the circumstances.<br><br>CMGMT-01A Section V.B delineates incidents reportable to DADS Regulatory.<br><br>Section V.C delineates incidents reportable to DADS State Office. | |

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| | 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. | Section V.D delineates incidents reportable to law enforcement.<br><br>A review of a limited sample of incident reports determined that for the most part reports were timely.<br><br>Through record review and document review it was apparent DSSLC had a standardized reporting system for incidents.<br><br>The daily meetings of the Incident Management Team and the comprehensiveness of other documents used in the reporting and review process, such as home logs, appeared to be effective mechanisms to quickly identify most issues that should have been reported and may not have been and to examine causation factors if any incident was reported late. | |
| | (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. | CMGMT-01A Section IV.A. describes immediate steps that must be taken to protect individuals, assess and treat injury, and secure evidence, and remove the alleged perpetrator from the scene. The policy does not, however, explicitly state an alleged perpetrator must be reassigned to not have contact with any individuals (although a review of the incident management process and incident reports indicates this is in fact the practice at DSSLC). The policy in this section states the alleged perpetrator be "removed from contact with the resident" leaving open the question of his/her ability to be reassigned to another work area working with a different set of individuals. In Section VI.D there is a clearer statement that says the alleged perpetrator is forbidden to have any contact with clients. DSSLC may want to revise this policy to remove any ambiguity. Section VI of this policy contains behaviorally oriented requirements directed at reassigned staff to ensure they cooperate and do not interfere with the investigation.<br><br>A review of a sample of incident reports, observation of the Incident Management Team meeting, and staff interviews confirm that alleged perpetrators are reassigned away from client contact job responsibilities.<br><br>The Facility Investigator, Incident Manager and the DFPS Investigator reported that for the most part staff is cooperative with their investigations. No one interviewed could point out any specific examples of noncooperation or acts that have compromised an investigation. | |
| | (c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms | CMGMT-01A Section III requires all staff to attend competency based training on preventing and reporting abuse and neglect pre-service and every twelve months. It also requires that supervisors will periodically assess employee knowledge and provide additional training as needed. A review of the curriculum confirmed that relevant and | |

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| | of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training. | appropriate topics are covered in the training.<br><br>From staff interviews it was evident that there is a high degree of clarity in understanding the abuse and neglect policy. Upon questioning most staff provided the correct responses immediately.<br><br>In a limited review of individual training records it appeared most staff had met the training requirements and those who had not attended the annual refresher were identified for follow-up by the staff training department. | |
| | (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. | CMGMT-01A Section III.C requires that DSSLC staff must sign a statement acknowledging zero tolerance for abuse, neglect, and exploitation of individuals and their reporting obligations. This is required at pre-service and every twelve months. A limited review of personnel and training records validates that DSSLC has a process in place to meet this requirement and maintain this documentation.<br><br>This review did not discover any instance of failure to report, and therefore subsequent personnel action.<br><br>Staff interviewed on this topic clearly understood there were consequences for not reporting the most common response being "you'll be fired." | |
| | (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. | CMGMT-01A Section III.F requires that the DSSLC will provide a training and resource guide regarding signs of and how to report abuse, neglect, and exploitation of individuals to the individuals served, their primary correspondents, and their legally authorized representative (LAR). It appears this guide is yet to be developed. There were some materials provided that was used in communicating this topic but they do not reflect what one would expect in a Resource Guide. It was also reported that this topic sometimes gets presented at meetings of the Family Association and sometimes comes up at annual PSP meetings when the family is present.<br><br>Several individuals who live at DSSLC were asked about reporting, and they had little knowledge on the subject. | |

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| | (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. | DSSLC has several posters it uses to promote rights and to advertise the abuse reporting hotline, including one which features a picture of an individual and his parents with the message "thank you for taking care of my family member! Thank you for keeping him/her safe from harm at all times" followed by hotline information.<br><br>For the most part postings were found in residential and day program areas.<br><br>DSSLC also includes reporting information on the back of employee ID badges which are worn around the neck. When talking to residential staff about how to report almost all quickly referred to their ID badge while answering. This appeared to be an effective way to ensure and reinforce reporting requirements. | |
| | (g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. | CMGMT-01A Section V.D requires immediate notification to law enforcement for "any suspicion of criminal activity". Most allegations of abuse, many allegations of neglect, and certain types of injuries could be considered "suspicious of criminal activity" and therefore could be reported to law enforcement. There is considerable lack of clarity as to what should be reported to law enforcement. From an internal DSSLC email, it apparently has been the practice since April 2009 to report all allegations of physical abuse, sexual abuse, and sexual exploitation to OIG which is considered law enforcement. It was also reported in an interview that all allegations of physical abuse are reported to local law enforcement. The monitoring team understands this subject is under statewide policy review to provide clearer direction to the SSLCs.<br><br>DSSLC, from documents reviewed, and from interviews, appears to refer appropriately to law enforcement, meaning from a limited sample nothing was discovered by the monitoring team that looked on its face as if it should have been referred to law enforcement but was not. | |
| | (h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's | CMGMT-01A Section V contains what appear to be all the necessary elements to comply with this section of the SA. It includes resources with phone numbers that persons can access if they feel there are concerns with regard to retaliation that are not being addressed at the facility level.<br><br>Through limited interviews and documentation review there was no evidence of retaliation apparent other than that noted below.<br><br>Most Direct Support Professionals reported little knowledge of, or personal experience with, retaliation. One DCP reported he was the subject of retaliation, the facility was very supportive of his concerns, and he felt the facility has zero tolerance of retaliation. | |

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| | failure to report an incident in an appropriate or timely manner. | | |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | DSSLC has an Incident Audit process which would, under many circumstances, detect non-reporting of injuries. The process was described as consisting of a file review of records and notes of a sample of individuals each month. If anything is discovered in this review that should have resulted in an injury report the auditor continues on the paper trail to validate proper reporting. If none is found, the auditor initiates follow-up action. Records of this auditing are nicely organized in a binder and documentation of the auditing activity is clear.<br><br>An example of this process showed that a review of Individual #382's record found a note entered by a Direct Care Professional indicating the individual had bitten his wrist and forearm. The auditor did not find an injury report or any nursing documentation and initiated follow-up activity with nursing and the Unit Director.<br><br>While this audit process is good there are several things which could improve:<br><br>1. The process could not be located in policy or found in any official DSSLC document.<br>2. The process could be timelier. The audit described above occurred in January, 2010, and was reviewing September, 2009, documents.<br>3. Files targeted for audit could be less random, perhaps targeting residential areas with unusually high or low numbers of injuries, or any criteria which might trigger interest.<br><br>The monitoring team was informed the process is being refined to enable more reviews, and more timely reviews, and looks forward to evidence of this in future visits.<br><br>DSSLC also has a Client Injury Specialist who reviews all injury reports and initiates follow-up activity if anything is missing from a report or if anything on the report appears to need clarification. This is a good process, and the Client Injury Specialist appears very knowledgeable, however the process focuses primarily on process and proper documentation. Several non-serious injury reports were reviewed that in the opinion of the monitoring team should have triggered more in-depth review. Individual #192 had a bruise on her breast, individual #332 had a reddened scratch to the labia area, and individual #530 had a bruise to the left eye. Because these injuries were classified as non-serious it appears the review of the circumstances, and to rule out abuse or neglect, occurs at the unit level. The appropriateness of this should be examined more closely by facility leadership. Also refer to comments on this subject in D-1.<br><br>A well developed Injury audit process usually includes some mechanism to identify injuries (that may or may not have been reported) that goes beyond reviewing paper. A | |

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| | | body check at bathing, documented by a nurse, is one mechanism to achieve this. Pre and post home visit body checks are sometimes part of such a system. It should be noted that Denton Policy Client Management-07 Absence Accountability (provided as a document request response for "policy/procedure that governs home visits") is in need of updating. In its present form, it contains little substantive information requirements that would promote client protection from harm requirements. | |
| D3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall: | CMGMT-01A Sections VIII (State Center Investigations), IX (State Center Unusual Incident and Final Investigation Reports), and X (Review of DFPS Final Investigation Report) contains most of the necessary elements to guide the facility's investigatory process. Issues identified by the monitoring team are noted in sections a – j below. | |
| | (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. | Section VIII.H provides policy/procedural direction for the conduct of facility based investigations. Supplemental guidance is contained in the Training Manual investigators receive from the state mandated training they attend. This manual includes sections on the investigative process, organizing an investigation, physical and demonstrative evidence, testimonial evidence, documentary evidence, and, drawing conclusions and reporting investigative findings.<br><br>Section VIII.A requires that investigators be trained; however, the type of training is not specified in this section. It is included in Section III.D and E. DSSLC requires a very specific training regimen for its investigators. It might be wise to reference it in this section of policy. Training in working with people with developmental disabilities is also not referenced although both investigators have many years of experience working with people with developmental disabilities before they became investigators. Being outside the line of direct supervision of an alleged perpetrator is also not referenced although in practice the organizational location of the investigators ensures this. | |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, | Policy contained limited information addressing the topic of staff cooperation with outside investigators. Most was in regard to the person being investigated. From interviews with DSSLC staff and DFPS staff, a high degree of cooperation was reported. This is due in part to the fact the DFPS investigators have been assigned to DSSLC for a | |

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| | and exploitation. | number of years and the facility has maintained an expectation of cooperation. Based on a review of a limited number of investigation reports and related documentation there was no indication that DSSLC had failed to cooperate with investigations conducted by DFPS or OIG. | |
| | (c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations. | DADS policy Section V.D refers to reporting to law enforcement.<br><br>CMGMT-01A also refers to reporting to law enforcement; however, as discussed in section D2-g, the ambiguity of what constitutes "suspicion of criminal activity", in the context of abuse and neglect, needs to be addressed through policy revision.<br><br>Document review confirmed multiple instances of incidents being referred to law enforcement. | |
| | (d) Provide for the safeguarding of evidence. | CMGMT-01A contains very little information or specific direction regarding the safeguarding of evidence. Policy revision is needed to more specifically identify where evidence is to be stored, who has access, and how a chain of custody is documented.<br><br>Based on a review of a limited number of investigation reports (both internal and DFPS), and through interview, there was no indication that any investigation was affected because of problems with safeguarding evidence. This is primarly a result of the sampled investigations not requiring evidence protection rather than necessarily good practice on the part of the DSSLC. | |
| | (e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, | The term "Serious Incident" is not explicitly defined in CMGMT-01A. Policy requires allegations of abuse or neglect to be reported to DFPS within one hour of discovery of the incident or knowledge of the incident. Policy requires incidents reportable to DADS regulatory to be reported within 24 hours of occurring or being reported (this covers serious injuries which are defined in policy). Policy also requires that investigation of serious incidents commence within 24 hours or sooner. Policy further requires that the facility must complete its investigation of "a significant incident within 14 calendar days (10 calendar days after June 1, 2010) of the incident being reported. The definitions section of CMGMT-01A also does not provide a definition of significant incident. The lack of an explicit definition of what constitutes a serious incident and a significant incident may lead to confusion or misunderstanding regarding these time constraints. Policy revisions should occur to address this.<br><br>A review of a limited number of incident reports confirmed that the timelines called for in DSSLC policy are generally followed. Timeliness of reporting will need to be tested in | |

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| | recommendations for corrective action. | future reviews | |
| | (f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material 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. | CMGMT-01A Section VIII.H provides specific requirements associated with investigations conducted by DSSLC staff. In reviewing DFPS Investigation Reports it is obvious they use a similar approach in conducting investigations. Each uses a standardized format in report presentation. Serious incidents are almost always investigated by DFPS. Based on a review of a limited sample of DFPS investigation reports DFPS investigations are generally thorough and produce reports that contain the elements called for in the Settlement Agreement. There are exceptions.<br><br>An allegation of neglect involving three staff and Individual #35 was found to be inconclusive by DFPS. DSSLC conducted a follow-up investigation and the Facility Director determined the allegation to be confirmed. In another case involving physical abuse of Individual #50 a staff person was discharged based on the DFPS investigatory finding. Upon appeal, the administrative Law Judge reinstated the employee citing "problems with the DFPS report and conclusions." Despite DADS request, the DFPS investigator did not appear at the hearing to testify.<br><br>These two examples suggest there is a need for improved collaboration between DADS, the SSLCs, and DFPS.<br><br>DSSLC and DFPS have a process for "streamlined investigations." These may occur in instances where the reporter is viewed as a chronic reporter whose claims are always unfounded, whose motive in reporting is apparently attention seeking. and who find staff removal and other aspects of an investigation reinforcing. DSSLC has identified Individuals #50, #306, and #374 as participants in this pilot project. This issue came up very late during the visit and the monitoring team was not able to determine what written guidelines and procedures, if any, were in place for streamlined investigations, especially if certain elements of a complete investigation were to be eliminated in order to streamline. There should be safeguards in place that establish clear (and legal) reasons why one individual gets his reported allegation "completely investigated" and another individual gets only a "streamlined investigation". Such a practice has implications in the area of rights as well as implications in the ICFMR compliance requirement of "complete and thorough" investigations. This process will be reviewed during compliance visits. | |
| | (g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to | CMGMT-01A Section X requires that the DSSLC DFPS Review Authority review final DFPS reports and make recommendations to the Director or designee within two working days of receipt. Section VIII.J provides that DSSLC based investigations of incidents be presented by the facility investigator to the Incident Manager within five working days of the incident. The IMC is then to make a final presentation to the Incident Management | |

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| | 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. | Review Team (IMRT) although policy does not state a timeframe for this to occur or what the expected outcome of this presentation is to be. The policy also does not specifically name the IMRT as the DFPS Review Authority, although it is clear in practice this is the case.<br><br>A limited review of investigation reports confirmed the above process occurs and included documentation that DSSLC follows up with DFPS whenever questions or ambiguity emerge in the review of a specific investigation. This included DSSLC initiating internal follow up investigations as noted in section D3-f. | |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident. | The limited sample of reports reviewed indicates that the reports accurately depict the event, the investigatory process, the outcome, and expected follow-up. DSSLC has a specific form it uses to document review of investigation reports. | |
| | (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 limited sample of reports reviewed indicates implementation of actions determined to be needed by the Incident Management Review Team (IMRT) were initiated by the IMRT and tracked. | |
| | (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. | A review of investigation files maintained in the Incident Managers office confirmed a well organized system for maintaining files. They are easily accessible. | |
| 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 | CMGMT-01A Section XIII contains the requirements for tracking and trending that will enable this element of the SA to be met. The data collection and report production appears to be in place. The monitoring team did not evaluate how DSSLC uses this information to assess performance and implement improvement plans. This will need to be examined in future reviews. | |

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| | 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. | | |
| 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 State policy on Abuse, Neglect and Exploitation does not contain information on prerequisites to allowing staff or volunteers to work directly with individuals. Section 3200.3 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers. The DADS Operational Handbook, Revision 09-21 effective 10/29/09 (Section 19000 Part E) requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff or volunteers to work directly with individuals.<br><br>Interviews with personnel staff, and the Director of Volunteer Services, and limited document review, confirmed these checks take place. A centralized computer based system is used for each process and the monitor found the reports it generates to be clear and understandable. These checks occur quickly so that in the case of staff results are returned well before the newly hired staff has completed new employee training. It was reported that volunteers are not allowed to work with individuals until the background check is completed. | |

**Recommendations:**

1. Revise DSSLC abuse and neglect policy to clearly articulate that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals..
2. Establish a process for the review and/or investigation of non-serious injuries to rule out abuse and neglect.
3. Examine policy on law enforcement referral of incidents leading to less ambiguous criteria for referral.
4. Refine the process for audits that determine whether significant resident injuries are reported for investigation.
5. Revise DSSLC policy to include provisions for safeguarding evidence with respect to incidents.
6. Revise policy to provide a definition of the term "serious incident" as used in the Settlement Agreement.

7. Requirements about training of investigators should be included in the DADS' policy on Abuse/Neglect/Exploitation, or if these requirements are elsewhere in State policy, reference to their location should be provided in the A/N/E policy. The DADS' policy also should include requirements that the Facility Investigator be outside the direct line of supervision of the alleged perpetrator.

| SECTION E: Quality Assurance | |
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| Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DADS Policy 003-Quality Enhancement<br>2. DSSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10<br>3. DADS Policy #001: Use of Restraint, dated 8/31/09<br>4. Denton Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09<br>5. Denton Policy CMGT-03B Drugs For Behavior Intervention dated 4/1/07<br>6. Denton Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09<br>7. Facility Restraint Analysis report for July-September 2009.<br>8. Facility Restraint QA reports for November 09 through March 2010.<br>9. HRC minutes from 2/24/10, 2/25/10, 3/5/10, 3/11/10, 3/18/10, and 3/24/10.<br>10. FY10 Restraints Trend Analysis 12/1/09 to 2/28/10<br>11. Injury Trending Report 2/28/10<br>12. Allegations Trend Report 2/28/10<br>13. Unusual Incidents Trend Report 2/28/10<br>14. QA Monitoring tools and summary reports for record review, psychology assessment, most integrated setting, consent, medication administration, meal observation, communication, active treatment, engagement monitoring, PNMP observation, and psychiatric assessment<br>15. Performance Improvement Council (PIC) minutes from meetings on 2/8/10, 1/26/10, and12/18/09,<br>16. Plan of Improvement monitoring tool and tracking log<br>17. Corrective Action Plan –Regulatory Survey 7/3/09.<br><br>**Persons Interviewed:**<br>1. Rebecca Wilkins, Director of Quality Assurance<br>2. Frank Padia, Director of Program Coordination<br>3. Deb Salsman, Director of Incident Management<br>4. Tammy Hampton, Incident Manager<br>5. Randy Spence, Director of Behavioral Services<br>6. Elaine Davis. Director of Training and Development<br>7. Six Direct Care Professionals.<br>8. Nine individuals served: #79, #231, #327, #337, #381, #386, #545, #624, and #727<br><br>**Meetings attended/Observations:**<br>1. Incident Management Team 3/29/10.<br>2. Health Status Team for 526C 3/30/10<br>3. Annual PSP for Individual # 327 3/31/10<br>4. Human Rights Committee (HRC) 3/31/10<br>5. Critical Incident team meeting 3/31/10<br>6. QMRP meeting 4/2/10<br>7. Living Area Observations: 513B, 515D, 528A, 528B, 528D, |

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| | 504B |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>The DSSLC has a QA policy that needs refinement to more specifically address QA activity at DSSLC. The current policy is largely a restatement of the State policy.<br><br>The facility engages in a great deal of QA monitoring resulting in many reports that ostensibly provide insight into performance in a number of subject areas. There is some question as to if the staff using the monitoring tools are sufficiently trained in knowing what to look for and how to assess a given data item. Some QA reports show a high degree of compliance that was not evident to the monitoring team during observation in the course of the review (e.g. certain elements in the meal monitoring tool).<br><br>DSSLC has the beginnings of what can become a very good QA system. The combination of the work tasks that occur in the QA office and the Systems Initiative office together represent a comprehensive set of data collection and tracking activities. There is much work ahead to refine processes, integrate information, and determine how best to use all the information flowing from these systems. |

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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 monitoring team's review of the State Policy 003- Quality Enhancement showed that it was consistent with the requirements of the Settlement Agreement (SA).<br><br>Denton SSLC Policy CMGMT-15 Quality Enhancement Process, dated 1/5/10 guides the facilities quality assurance processes. Section I-C of the policy describes data collection requirements; however, an organized system to meet the requirements of this policy appears to be in a developmental stage. For example, the QA plan does not specify the frequency of monitoring, who monitors, what tools are to be used, how data are to be put together, who reviews reports, and similar elements typically found in a comprehensive QA plan. The various monitoring tools used (record review, psychology assessment, most integrated setting, consent, medication administration, meal observation, communication, active treatment, engagement monitoring, PNMP observation, and psychiatric assessment ) provide the start of a good foundation for QA. The work activities of the Incident Auditor in the QA Department were particularly well organized and seemed well-managed.<br><br>DSSLC has another process managed outside the QA Department to monitor and measure progress towards meeting the terms of the Settlement Agreement. This consists of a Plan of Improvement document which is extensive and comprehensive. | |

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| | | These multiple data inputs, once organized into a comprehensive QA plan, should provide useful evaluation information that can lead to improved program performance over time.<br><br>Policy CMGMT-15 is for the most part a restatement of the State policy with some additions specific to the DSSLC such as processes conducted by Program Compliance Monitors, the Incident Auditor, audits of medical care, and activities of the QA nurse. This document appears to have limited utility as something which would facilitate effective implementation of a QA program. It describes the required expectations for a QA program, including necessary data elements called for in the SA, but it does not provide facility specific information as to the work processes that would cause these requirements to be met.<br><br>DSSLC does not have a document that would be characterized as a Quality Assurance Plan. In response to the document request asking for the Quality Assurance Plan, a set of the monitoring tools were provided.<br><br>A QA Plan should address subjects such as what is going to be monitored, by whom, at what frequency, what other data are to be collected, how data are to be organized for analyses, who analyzes data, what data are to be used for, and similar activity that allows the organization to understand how things are working, what and where things seem to be working well, what and where improvement is needed, and other elements designed to initiate organizational improvements, particularly systemic improvements.<br><br>Despite the lack of a written QA Plan, the DSSLC engages in a great deal of QA activity and should be commended for this. Through the use of a comprehensive set of monitoring tools much data is gathered in key subject matters and summarized and tracked. Tracking and trending data is produced relatively timely. It is unclear exactly who uses these reports for what purpose and how, or if, the analysis of these data effects organizational change. | |
| E2 | Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; | Data summaries are routinely prepared. There was little evidence of data analysis or related activity which would attempt to equip organization leaders with information to better understand problems and issues that can lead to systemic changes that improve organization performance.<br><br>The Performance Improvement Council appears to be one vehicle DSSLC uses to review and assess QA data and reports. This Council includes in its membership virtually all key program and clinical management staff of the facility. The agendas reviewed seem to key off the Plan of Improvement document which exists primarily to track and monitor SA | |

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| | the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur. | implementation. The meeting minutes reviewed (December, 2009; January and February, 2010) did not contain enough information to determine how much substantive discussion occurred. For both the January and February meeting under "action to be taken" the word "none" was noted for each discussion area. It would seem that because of the membership of this group it could become an important forum for assessing QA information and determining appropriate organizational responses to the analysis of QA data.<br><br>Some limited evidence of corrective action plans responding to specific findings from specific monitoring was evident although that was not a focus of this review. Future reviews will need to assess this in more detail. | |
| E3 | Disseminate corrective action plans to all entities responsible for their implementation. | The limited number of corrective action plans reviewed by the monitoring team included entries as to responsible parties, and in some cases, who is assigned to conduct follow-up monitoring to ensure intended actions were taken. This form also had a column to enter the type of documentation which is being used to validate completion of the intended actions. | |
| E4 | Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified. | Refer to E3 | |
| E5 | Modify corrective action plans, as necessary, to ensure their effectiveness. | Refer to E3 | |

**Recommendations:**
1. DSSLC needs to develop a formal Quality Assurance plan that incorporates all current activity that is QA related.
2. Once developed, the leadership of the Facility should determine if there is any additional QA activity that is needed to ensure the plan is comprehensive and when fully implemented will ensure sustained compliance with the SA.
3. DSSLC needs to identify a more formalized process than what was evident to the monitoring team for the review of QA data and planned corrective actions, including the QA related activity associated with the Plan of Improvement process and the work of the Performance Improvement Council and any other groups or committees that exist to assess performance and recommend improvement plans to facility leadership.

| SECTION F: Integrated Protections, Services, Treatments, and Supports | |
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| Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DADS Policy #001: Use of Restraint, dated 8/31/09<br>2. DSSLC Policy Client Management-12 – Development, Monitoring, and Revision of Individual Habilitation Plans<br>3. Denton Policy CMGMT-20 Limitation of Restraint as a Crisis Intervention dated 11/05/09<br>4. Denton Policy CMGT-03B Drugs For Behavior Intervention dated 4/1/07<br>5. Denton Policy CMGMT-21 Dental/Medical Sedation and Restraint dated 11/05/09<br>6. PBSP and Safety Plan for individual's #337, # 381, #537, and #269.<br>7. Facility Restraint Analysis report for July-September 2009.<br>8. Facility Restraint QA reports for November 09 through March 2010.<br>9. PSPs for Individuals #50, #374, #209, #461 and #624.<br>10. PSP Addendums for Individuals #50, #374, and #624.<br>11. HRC minutes from 2/24/10, 2/25/10, 3/5/10, 3/11/10, 3/18/10, and 3/24/10.<br>12. Medical Care Plan Monthly Review Notes for February, 2010 for Individuals #138, #568, #409, #335, #419, #496, and #569's<br><br>**People Interviewed:**<br>1. Rebecca Wilkins, Director of Quality Assurance<br>2. Frank Padia, Director of Program Coordination<br>3. Deb Salsman, Director of Incident Management<br>4. Tammy Hampton, Incident Manager<br>5. Randy Spence, Director of Behavioral Services<br>6. Elaine Davis. Director of Training and Development<br>7. Six Direct Support Professionals<br>8. Nine individuals served: #79, #231, #327, #337, #381, #386, #545, #624, and #727<br><br>**Meeting Attended/Observations:**<br>1. Incident Management Team 3/29/10.<br>2. Health Status Team for 526C 3/30/10<br>3. Annual PSPs for Individual # 327, #568, and #772<br>4. HRC 3/31/10<br>5. Critical Incident team meeting 3/31/10<br>6. QMRP meeting 4/2/10<br>7. Personal Futures Focus Worksheet (PFW) Meeting for Individual #334 3/31/10<br>8. Human Rights Committee Meeting, 3/31/10<br>9. Living Area Observations: 513B, 515D, 528A, 528B, 528D, 504B |

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| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:** DSSLC Policy Client Management – 12 Development, Monitoring, and Revision of Individual Habilitation Plans, dated 5/29/09, describes the expectations for PSP planning. There is little in this document that speaks to integrated and collaborative program planning.<br><br>The current PSP process meets some of the technical requirements of the Settlement Agreement (SA) however most of the elements required in Section F were either not developed or not thoroughly implemented, making substantive baseline assessment difficult. The monitoring team is aware this format, and accompanying instructions, are subject to a significant modification and that a statewide workgroup is being convened to develop a PSP policy that will refine the PSP process in a manner intended to facilitate compliance with the SA. Comments in this section are limited because of this. Because of this policy development the monitoring team is not specifically commenting on the adequacy of various provisions of DSSLC Policy Client Management – 12.<br><br>Overall, through document review, interview, and meeting observation there was little evidence of departments and disciplines coming together throughout the year, and in anticipation of the annual PSP planning process, to assess individual needs and develop service strategies in an integrated manner. |

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| **F1** | **Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall: | | |
| F1a | Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. | The Personal Support Team (PST) meetings are facilitated by an assigned QMRP. PSP meetings for individuals #327 and #772 consisted largely of individual team members reading or summarizing reports with little substantive discussion across disciplines. The lack of integrated planning observed at PSP meetings seems to translate to the lack of integrated service delivery observed by the monitoring team in day to day service delivery.<br><br>Some examples of integrated planning did occur. Observation of individual #568's PSP meeting demonstrated active participation of PST members, her mother and guardian. The nurse case manager present a thorough review of individual #568's health status and nursing objective and plans for the coming year. This was evident in review of the excellent Annual Nursing Assessment and Summary. The HMP was included in the PSP. The PST discussed the concerns and possible actions. | |
| F1b | Consist of the individual, the LAR, the Qualified Mental Retardation | Through observation, PSP meetings typically had appropriate staff and others in attendance. A limited review of PSP documents also suggests that for the most part PSP | |

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| | 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. | attendance is appropriate. Despite this observation, from the limited document review and meeting observation, there was little indication that Direct Care Professionals (DCPs) participated in the planning process in a meaningful way. In most cases the role of the DCP seemed to be one of supervising the individual and intervening in inappropriate behavior.<br><br>DCPs interviewed during the tour provided a variety of responses as to their input into PSP processes, their participation in planning meetings, and any regular communication they had with non-unit based staff (primarily clinical) about the needs, services, and supports of the people they worked with. Three of the four DCPs questioned on this topic stated they had never been to a PSP meeting for any of the individuals they work with. Two of those three had worked at DSSLC for over six years. Some responses from DCPs generally reflected a lack of regular and substantive dialogue with QMRPs and clinical staff. | |
| 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. | Individuals are not provided with comprehensive assessments in response to significant events or changes in status. For example:<br>• Individual #364 had a choking event on 3/8/10. In response to the incident, the individual received a general mealtime observation rather than a full tableside assessment<br>• Individuals #326, #776, #499, #711, #329, #248, 509 had incidents of pneumonia. The incident was discussed at the NMT meeting but there is no evidence of assessment or follow up completed by Habilitation Therapies.<br>• Individual #703 had falls occurring on 1/3/10, 1/30/10, and 2/1/10; however, there was no evidence that the individuals received an assessment or follow up by Habilitation Therapies.<br>• Individual #163 had falls occurring 2/4/10 and 3/4/10; however, there was no evidence that the individuals received an assessment or follow up by Habilitation Therapies.<br>• A system does not currently exist that ensures individuals who receive enteral nourishment receive annual assessments that address the medical necessity of the enteral feedings as well as potential pathways to return to oral intake. Comprehensive evaluation should be utilized to determine their feasibility of returning to oral intake and to allow for comparison of swallow function from year to year. Identified in these evaluations should also be strategies that have been developed to transition an individual to oral intake, if appropriate. | |
| F1d | Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines | See F1c above | |

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| | the protections, services, and supports to be provided to the individual. | | |
| 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). | While no overt areas of noncompliance with ADA and Olmstead were observed it will be important for the new state policy to describe in detail how provisions of ADA and Olmstead are expected to be addressed in PSP planning.. During PSP meetings, the PST identified the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation if the person were to move to a more integrated appropriate setting. Although these were individualized according to the assessed needs of each individual, they also tended to mirror those protections, services, and supports being provided by the Facility. | |
| **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: | The DADS policy on integrated PSPs will be undergoing review and revision. It is anticipated the new state policy will clearly establish expectations for integrated program planning and establishes training for SSLC staff to ensure the operational aspects of implementation meet the intended outcomes. The monitoring team looks forward to reviewing the DADS policy once it is completed and in reviewing the DSSSLC implementation. | |
| 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: | The PSPs reviewed and the meetings attended had little discussion or activity in most of the six areas delineated below. Clearly, more definitive policy direction and competency based training is needed to ensure progress in this area of the SA. The PSP document did contain some required elements as noted below. | |
| | 1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation; | "The PSP document includes sections on "What's Most Important to the Person?", "How Is This Supported?", and "Achievements and Abilities." This information is a good start but it was difficult to find information in PSPs that used this information to prioritize needs, increase community participation, and develop supports needed to eliminate barriers. | |
| | 2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the | PSPs reviewed contained limited information that would address this requirement. The Action Plans contained in the PSP document did not usually contain measurable goals, strategies, or supports. Most often they were simple statements such as "will turn the radio off". For individual #461 in the healthcare area the overall goal is listed as "achieve/maintain the highest possible level of health" but listed under steps are the | |

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| | 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; | terms "constipation", or "dandruff". These are conditions, not steps to improve health.<br><br>The PSP for Individual #209 had multiple blank entries in the Action Plan section for Responsible person, when, where to record, and comment columns. The monitoring team asked for PSPs for specific individuals. This particular PSP document had a 4/27/09 date in the lower right hand corner for a PSP date of 8/20/09. It could be the monitoring team was looking at some type of draft. Other PSPs that did have complete entries often lacked substance as noted in the previous paragraph. | |
| | 3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual; | Through record review, interview, and observations there was little evidence of integrated planning. For example:<br>• While the PT/OT assessments have been completed, they are not adequately integrated into the PSP. Upon review of the PSP, the assessments are referenced but are not integrated as part of the summary of the individual and the PSP did not clearly provide information regarding the individual's strengths and weaknesses and how the proposed interventions provided in the PT/OT assessment will benefit the individuals in living a more independent and functional life.<br>• Results from the speech assessment are only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit are not clearly integrated into the PSP. Other than mention the device and or assessment, the PSP does not contain information regarding how the individual communicates and strategies that staff may utilize to enhance communication.<br>• Personal Support Plans (PSPs) for individual #67, individual #393, individual #720, and individual #539 were reviewed for psychiatric aspects of care. Psychiatric care was addressed only in very general terms, for example by listing behavioral symptoms for which psychotropic medications were prescribed, by providing broad statements about the need to monitor those medications, and by providing statements about efforts to reduce maladaptive behaviors. As outlined in sections J8, J9 and J13, many aspects of psychiatric care were not integrated into the overall Positive Behavior Support Plan (PBSP), and psychiatrists did not provide independent summaries of their clinical work. As a result, the Qualified Mental Retardation Professional (QMRP) and others appeared to lack information needed to facilitate full interdisciplinary discussion at the PSP meeting.<br><br>To determine the adequacy of training in providing team members with the necessary skill sets to effectively collaborate in integrated planning and in developing and implementing comprehensive and effective plans for individuals, this provision of the SA will be reviewed in future monitoring visits as the expected revised state policy is implemented. | |

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| | 4. Identifies the methods for implementation, time frames for completion, and the staff responsible; | The materials provided to the monitoring team when a request for a PSP was made often contained minimal information that would contribute to integrated planning and the degree of specificity called for in the SA. A larger sample of complete PSPs and active records will be reviewed at the first compliance visit to determine whether this reflects a lack of information in the record or whether related but necessary documents are in the record but were not provided. | |
| | 5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and | The materials provided to the monitoring team when a request for a PSP was made often contained minimal information that would contribute to integrated planning and the degree of specificity called for in the SA. A larger sample of complete PSPs and active records will be reviewed at the first compliance visit to determine whether this reflects a lack of information in the record or whether related but necessary documents are in the record but were not provided. | |
| | 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. | The PSPs reviewed did not contain any information that would address this element of the SA. Data to be collected are identified in PBSPs but are not routinely identified for all areas of supports. For example, measurement of indicators of risk or progress is not routinely identified for PNMPs.<br><br>Interobserver agreement or other evidence of reliability of the behavioral data was not checked. Therefore, even the behavioral data do not provide adequate indication of efficacy of treatment. | |
| 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. | From documentation review, interviews, and observations during this review it did not appear that coordination of goals, objectives, anticipated outcomes, services, supports, and treatments flowed from the PSP document and the PSP meeting. Individuals, for the most part, are receiving services; however, they do not appear to be coordinated.<br><br>For example, as outlined in sections J8, J9 and J13, many aspects of psychiatric care were not integrated into the overall Positive Behavior Support Plan (PBSP), and psychiatrists did not provide independent summaries of their clinical work. As a result, the Qualified Mental Retardation Professional (QMRP) and others appeared to lack information needed to facilitate full interdisciplinary discussion at the PSP meeting. | |
| F2c | Commencing within six months of the Effective Date hereof and with | From limited interviews it appears DCPs and other staff have access to PSPs. PSPs reviewed were comprehensible; however, for the most part they lacked sufficient detail | |

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| | full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it. | to be of much use to staff charged with implementation. | |
| 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. | From the limited record review it did appear that for the most part these monthly reviews took place. The lack of qualitative substance in most PSPs described elsewhere in this document made this monthly review, for many individuals, perfunctory. For example, individuals with communication devices are not consistently followed by the Speech Pathologist resulting in no analysis of the data by the plan's author. Review of Individuals #138, 568, 409, 335, 419, 496, and 569's Medical Care Plan Monthly Review Notes for February, 2010 indicated that nursing completes monthly notes that assess the progress and efficacy of health related interventions, Nursing Service Objectives were reviewed and continued with no change unless otherwise indicated in the narrative. | |
| 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 | At this point the monitoring team does not believe additional training in the overall requirements for PSP planning should occur until the planned development of statewide policy and procedure intended to ensure compliance with this section of the SA is completed.<br><br>There are some areas that merit immediate attention, Refer to provision O-5 for additional information relevant to Physical and Nutritional Management.<br><br>The new policy will hopefully include specific training requirements consistent with the SA. | |

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| | 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. | | |
| F2f | Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension. | The monitoring team did not review any new admissions during this visit. | |
| 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. | DSSLC produced a document entitled "Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 5/8/08. Through interview it was determined this document is not in use by the QA staff.<br><br>Hopefully the statewide policy currently under development will include specific provisions addresses PSP QA. | |

**Recommendations:**

1. Once State Policy is established the DSSLC will need to use it to create its own policy that can describe in detail, and in operational terms, the elements that will be necessary to lead to compliance with the elements of the SA.
2. DSSLC needs to take steps to qualitatively improve its assessment processes and to begin a process where there is cross disciplinary discussion of assessment results and meaning. This process needs to include both routine annual and quarterly assessments and assessments needed due to change in an individual's status that might lead to PSP revision. The process also needs to ensure that cross-disciplinary discussion provides information valuable for the assessment and for PSP planning that integrates assessment results.
3. The following recommendations are offered with regard to training staff on the interdisciplinary approach and individualized planning process:

a. Methodologies for determining QMRPs' as well as other team members' competence with regard to the development and implementation of PSPs should be developed and/or implemented. In order to measure a QMRP's competency in the development of PSPs, a two-step process should be considered. Specifically, tools should be developed to evaluate a QMRP's ability to facilitate the team meeting, and another to evaluate the QMRP's ability to develop a PSP that meets all of the related requirements.
b. QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, including conflict resolution, particularly as is relates to the interdisciplinary team process.
c. As teams are trained on the new PSP policy and format, a focus should be on all PST members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
d. Monitoring of PSP planning sessions should address not only whether all steps in the PSP planning process are carried out but also whether integrated planning occurs, including who participates in discussion and whether assessments and services are influenced by integrated discussion. This can provide an opportunity to provide feedback and coaching to PST members.

4. DSSLC needs to establish a mechanism where Direct Support Professionals can develop a working understanding of the PSP process, the interdisciplinary nature of it, the benefits of integrated planning, and the relationship to all this to their daily work.

| SECTION G: Integrated Clinical Services | |
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| Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement, including but not limited to the items below.<br>**Documents Reviewed:**<br>1. DSSLC Policy Client Management-12 – Development, Monitoring, and Revision of Individual Habilitation Plans<br>2. PSPs for Individuals #50, #81, #95,#138, #209, #374, #461 #508, #624, #645, #713, #720, and #759.<br>3. Medical Care Plan Monthly Review Notes for February, 2010 for Individuals #138, #568, #409, #335, #419, #496, and #569's<br>4. Record Reviews of Individuals #703, #11, # 633, #163, #416, #768, #766, #536, #552, #499,#496, #453,#672, #19, #392, #589, #524, #118, #245, #449, #327, #364, #44, #574, #240, #1, #248, #326, #329, #776, and #509<br>5. Additional documents reviewed by the members of the monitoring team, as identified in other sections of this report<br><br>**People Interviewed:**<br>1. Dora Tillis, Assistant Director of Programs<br>2. Frank Padia, Director of Program Coordination (QMRP Coordinator)<br>3. Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report<br><br>**Meeting Attended/Observations:**<br>1. Health Services Team Meeting, 504B, March 20, 2010<br>2. PSP and other meetings attended by members of the monitoring team, as identified in other sections of this report. |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Although examples of integrated planning and review exist, there are many opportunities to improve integration. The PSP process needs to be revised; consisted largely of individual team members reading or summarizing reports. |

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| G1 | Commencing within six months of the Effective Date hereof and with full implementation within three | There were some examples of integrated planning and review, along with numerous opportunities to improve integration. | |

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| | years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need. | PSP meetings for individuals #327 and #772 consisted largely of individual team members reading or summarizing reports with little substantive discussion across disciplines. The lack of integrated planning observed at PSP meetings seems to translate to the lack of integrated service delivery observed by the monitoring team in day to day service delivery.<br><br>Psychiatrists worked with colleagues from medicine and psychology in a collegial and respectful manner. DSSLC psychiatrists received strong support from other professional services: Pharmacy support was provided through day to day communication, through participation by pharmacists in healthcare team meetings, and through comprehensive QDDRs. DSSLC nurses were engaged meaningfully in the day-to-day behavioral health care and they collaborated as participants in multidisciplinary setting such as the HST meetings.<br><br>Per section F2, J8, J9 and J13, many elements needed for a full integration of psychiatry and psychology were lacking. Nevertheless, a good working relationship between the psychology and psychiatry staff was both reported by staff and observed. This allowed for an open exchange of ideas and was noted to facilitate the assessment and treatment development process.<br><br>To promote integration of care, physician-led quarterly Health Status Team (HST) meetings in which core staff from medicine, nursing, psychiatry, pharmacy, allied medical fields, QMRP and other departments provided timely updates of medical, safety and risk issues. These matters were then integrated into the quarterly review of the PSP.<br><br>Per sections J12, J15, HCG II, and HCG III, some elements needed for a full integration of psychiatry and medicine (including neurology) were lacking. For example, although DSSLC has been able to reinstate a twice-monthly on-site neurology clinic, staffed by a consulting neurologist, there was an example in which complete information on behaviors of concern was not communicated to the neurologist. Also, nurses carried out monitoring of side effects of medications, but the system used for review of these documents by the psychiatrist and PCP was unclear and does not specify how that there is collaborative review and decision-making when appropriate.<br><br>Psychiatry and pharmacy were generally well integrated, although the system to monitor psychiatric polypharmacy could be improved.<br><br>Psychiatrists were not involved in the evaluation of individuals who received pre-treatment sedation.<br><br>The Nutritional Management Screening Tool was too narrow in focus and did not | |

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| | | adequately include physical management aspects that may impact health status. Additionally, the NMT screening and the screening forms for aspiration and choking as well as other screening related to Physical and Nutritional Management (including Constipation and GI issues, for example) are not related to each other therefore resulting in increased fragmentation between areas of practice.<br><br>Rationales and descriptions of communication interventions regarding use and benefit are not clearly integrated into the PSP. | |
| 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. | This will be reviewed at the first compliance visit. | |

**Recommendations:**

1. Development of integrated planning is a long and difficult process. The Facility should begin to identify opportunities for integrated planning and engage staff in identifying means to make the PSP/PST process an interdisciplinary planning process rather than a reporting process.
2. Continue to identify opportunities for integrated planning, assessment, and intervention.

| SECTION H: Minimum Common Elements of Clinical Care | |
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| Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement, including but not limited to the items below.<br>**Documents Reviewed:**<br>1. PSPs for Individuals #50, #81, #95,#138, #209, #374, #461 #508, #624, #645, #713, #720, and #759.<br>2. Record Reviews of Individuals #703, #11, # 633, #163, #416, #768, #766, #536, #552, #499,#496, #453,#672, #19, #392, #589, #524, #118, #245, #449, #327, #364, #44, #574, #240, #1, #248, #326, #329, #776, and #509.<br>3. Additional documents reviewed by the members of the monitoring team, as identified in other sections of this report<br><br>**People Interviewed:**<br>Interviews with various discipline staff by the members of the monitoring team, as identified in other sections of this report.<br><br>**Meeting Attended/Observations:**<br>PSP, HST, and other meetings attended by members of the monitoring team, as identified in other sections of this report. |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Provision of clinical services is variable across disciplines. Some aspects of clinical services meet current, generally accepted professional standards of care, including those defined in the SA. Other aspects do not yet meet these standards. Improvements are needed in assessment, identification and use of indicators of efficacy, and monitoring of care. |

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| H1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs. | Provision of assessments on either a regular basis or in response to changes in an individual's status was variable across disciplines.<br><br>Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar. They included comprehensive information.<br><br>The majority of the individuals living at DSSLC have not been provided with comprehensive Speech or Adaptive and Augmentative Communication (AAC) assessments. | |

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| | | A minority percentage of the reviewed records included a formal assessment of adaptive behavior within the previous 12 months, an intellectual assessment within the previous 7 years, a formal assessment of psychopathology based upon an objective instrument or rating scale, or a review of biological, physical and medical conditions beyond a listing of symptoms or diagnoses.<br><br>There are currently 2.5 Speech Pathologists with 1 Speech Tech on staff at DSSLC. This has resulted in a very large caseload of approximately 220 individuals per therapist. Carrying a caseload this large makes it increasingly difficult to provide proactive involvement as most of the clinician's time is spent completing assessments and provides little time for continued supports to be provided by the Speech Pathologist.<br><br>Additionally, there are only Five Physical Therapists and Three Dietitians on staff. Like Speech Therapy, this results in extremely large caseloads thus making proactive care extremely difficult to obtain. Refer to provision R.2 for information regarding lack of appropriate Speech 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. | Psychiatric evaluations and diagnoses are consistent with the Diagnostic and Statistical Manual, per sections J2 and J6.<br><br>Review of individuals' #s 138, 568, 409, 335, 419, 496, and 569s' Annual and Quarterly Nursing Assessments and accompanying Health Maintenance Plans and Acute Care Plans as well as integrated progress notes validated the use of North American Diagnoses Association (NANDA nursing diagnoses for health issues identified requiring nursing interventions. This was a positive finding because the use of NANDA, a standardized nursing language for documentation of care, is vital both to the nursing profession and the direct care nurse. The benefits to using this classification for nursing diagnoses include: better communication among nurses and other health care providers, increased visibility of nursing interventions, improved nursing care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency. | |
| 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. | Provision of treatments and intervention based on assessments and diagnoses is variable across disciplines.<br><br>Identification of risk is not consistent with clinical need and does not adequately trigger a risk-based frequency of assessments. As a result, intervention may not be timely if an individual's health or behavioral risk changes.<br><br>For development of PBSPs, functional assessment is used; however, many functional assessments are not adequate for use in planning interventions, and replacement behaviors often do are chosen based on the identified functions of behavior. | |

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| | | An example was found in which inadequate care following a bunionectomy led to poor results and loss of function. | |
| 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. | Use of clinical indicators of efficacy is variable across services and disciplines. In some cases (such as physical and nutritional management), monitoring is done by people who do not have the clinical knowledge needed to identify subtle changes. In others (such as nursing), comprehensive information is provided.<br><br>Clinical indicators of efficacy of psychiatric services are determined in a justified manner per provision J2. Behavioral data related to psychiatric and behavioral services, however, consisted largely of the individual's performance on targets for overall behavioral treatments, such as physical aggression toward others (PAO), verbally disruptive behaviors (VDB), self-injurious behaviors (SIB), and physically disruptive behaviors (PDB). There was little use of generally accepted observer rating tools for signs and symptoms of disorders like anxiety and depression. Furthermore, because reliability of the behavioral data was not checked, even the behavioral data do not provide adequate indication of efficacy of treatment.<br><br>Monitoring of physical and nutritional management plans focuses primarily on whether or not equipment is available and staff are implementing the strategies as listed in the PNMP and dining plan. The effectiveness of the plans was not clearly monitored.<br><br>Nursing assessments include comprehensive information. The nursing case managers need to continue to strengthen comment section and summaries to include whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working | |
| H5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals. | Refer to discussion of PTR and HST meetings in J1 and L1. These provided a means for monitoring of health status. In addition, nursing quarterly and annual reviews were done timely.<br><br>Refer to provisions O.7 and P.4 for additional information regarding the PNM and OT/PT monitoring process. Although monitoring occurred, it did not provide adequate information about health status. | |
| 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. | There are numerous opportunities for review and modification of interventions. There are regular HSTs, for example. It is sometimes unclear whether modifications are based on clinical indicators reported at those reviews. For example, PBSPs were continued in the absence of demonstrated effectiveness. Monitoring of frequency, timeliness, and appropriateness of interventions will be done at compliance reviews. | |

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| H7 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H. | The Facility needs to establish policies and procedures to ensure assessments are timely and include minimum required components.<br><br>For example, there was not a clear process in place in which the PNMP team is notified should a sign or symptom associated with aspiration occur. Currently, notification relies on DCPs determining an issue is severe enough to contact nursing then nursing determining an issue is severe enough to contact the physician and make a referral. This results in clinical judgments regarding PNM being made by individuals who are not clinicians and too many opportunities of signs and symptoms that are not overt to be missed therefore resulting in a more reactive than proactive approach. During several meals on 522b, 513b, 514a and 522a, potential signs associated with aspiration were observed but no interventions were provided and no referrals were made in response to these issues. Processes are not in place that establish integrated program review, monitoring, and planning for development and monitoring of PNMPs. | |

**Recommendations:**

1. Review the status of adaptive behavior and intellectual functioning assessments to ensure they are within timelines that meet current, generally accepted professional standards and are sufficiently current to be meaningful and contribute to the development of programs and services.
2. Ensure resources are adequate to complete communication and nutritional management assessments and provide proactive treatment planning and care.
3. Develop processes to monitor timeliness of modifications in treatments and interventions.

| **SECTION I: At-Risk Individuals** | |
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| Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Record Reviews of Individuals #703, #11, # 633, #163, #416, #768, #766, #536, #552, #499,#496, #453,#672, #19, #392, #589, #524, #118, #245, #449, #327, #364, #44, #574, #240, #1, #248, #326, #329, #776, and #509.<br>2. Requested tour documents including but not limited to:<br>a. Risk lists associated with skin breakdown, falls, pneumonia, choking, weight loss and weight gain<br>b. Occupational and Physical therapy Assessments<br>c. Nutritional Management Meeting minutes<br>d. PNMP clinic minutes<br>e. HST minutes<br>3. The applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management<br><br>**People Interviewed:**<br>1. Donna Groves, OTR, Director of Habilitation Services<br>2. Joy Sibley SLP, Director of Communication Therapy<br>3. Meeting with RN Case Managers<br>4. Dr John Beall, RN, MSN, DNP, Chief Nurse Executive<br>5. Sherry Courtney, RN, Operations Nurse<br>6. Sibylle Graviett, RN, RN Case Manager Leader<br>7. Rebecca Wilkins, Director of Quality Assurance<br>8. Frank Padia, Director of Program Coordination<br>9. Deb Salsman, Director of Incident Management<br>10. Tammy Hampton, Incident Manager<br>11. Randy Spence, Director of Behavioral Services<br>12. Elaine Davis, Director of Training and Development<br>13. Six Direct Support Professionals (JS, CD, LD, AL, JF, and RR)<br>14. Nine individuals served #727, #231, #624, #337, #381, #327, #386, #79, and #545.<br><br>**Meetings Attended/Observations:**<br>1. Observations of 503b, 522b, 512b, 513b, 502c, 502d, 514b, 513a, 522a, 522c, 522d513B,,515D, 528A, 528B, 528D, and 504B, living areas and dining rooms.<br>2. Incident Management Team 3/29/10.<br>3. Health Status Team for 526C 3/30/10<br>4. Annual PSP for Individual # 327 3/31/10<br>5. HRC 3/31/10<br>6. Critical Incident team meeting 3/31/10 |

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| | 7. QMRP meeting 4/2/10<br>8. HST quarterly<br>9. NMT meeting<br>10. RN Case Managers Meeting |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:** There is a variety of information available from which to identify individuals who are potentially at risk. The policies and procedures for a risk management system should draw together the various assessment instruments, other relevant information, and procedures into one process that can reliably identify individuals whose health or well-being place them at risk and need special planning to mitigate risk. A process to bring this all together should include a review of each assessment tool to ensure they measure what is intended to be measured and criteria to assign risk levels as objectivelyas possible.<br><br>Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. Therefore, DSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that it identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services. |

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| I1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. | The risk assessment screening, assessment, and management system does not appear to function in a manner that identifies risk correctly and causes appropriate follow-up actions to occur.<br><br>Many DSSLC individuals have medical conditions that seriously complicate the swallowing and digestion of their food and beverages as well as increase their difficulty in being able to safely manage their oral secretions.<br><br>Aspiration Pneumonia is often a preventable condition that results from the accumulation of foreign materials (usually food, liquid, or reflux) in the lungs. DSSLC lists only 29 individuals as at "high risk" for aspiration and two individuals who are at "high risk" for choking yet several individuals who do not appear on the center's high risk list were hospitalized for aspiration or choking related events or identified through Videofluoroscopy or by team members as having symptoms drastically increasing the risk of aspiration. Based upon observation, there were a significant number of individuals who were observed to be at "high risk" but were listed as being at "low risk" according to their screening forms.<br><br>Thorough review of the "At Risk" policy revealed multiple issues. One was that the center was incorrectly following the policy as DSSLC was placing the majority of their individuals as being at "low risk" when they should have been placed as at "medium risk." Second, the | |

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| | | policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. Following the policy as written would result in DSSLC having the majority of its population listed as "Medium Risk" since most of the individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at DSSLC.<br><br>Overall risk is determined primarily by the physician and does not frequently follow guidelines set forth by DSSLC. For example:<br>• Individual #364 had a choking event within 30 days of the HST meeting; however, the risk level assigned was "Medium" instead of "High" as stated in the risk guidelines.<br><br>Examples that the current system was not accurately identifying those who are at risk include:<br>• Individual #633 has a diagnosis of gastritis, hiatal hernia, Barrett's Esophagus, and Schatzkis B ring; however, the individual was listed as being at a "Low Risk" of aspiration/choking and GI issues.<br>• Individual #766 has a diagnosis of GERD, hiatal hernia, esopahagitis, and aspiration pneumonia; however, the individual was listed as being at a "Low risk" of aspiration/choking and GI issues.<br><br>Identification of skin breakdown risk was also not adequately identified. For example:<br>• Individual #496 had episodes of skin breakdown on multiple body parts occurring on 2/15/09, 3/16/09, 7/13/09, 8/25/09, 10/1/09, 11/12/09, and 11/16/09; however, is not listed as being at a "High risk" for skin integrity.<br>• Individual #19 had episodes of skin breakdown occurring on 1/30/09, 5/14/09 and 8/18/09 however is listed as being "low risk" for skin breakdown.<br><br>As with other areas; falls are not being adequately categorized as it relates to risk. For example:<br>• Individual #703 had falls occurring on 1/3/10, 1/30/10, and 2/1/10 but was listed as being at a "Low Risk" of injury.<br>• Individual #163 had falls occurring on 2/4/10 and 3/4/10 and again was listed as being at a "Low Risk" of injury.<br><br>In addition to the issue noted above, there was no criterion that guides the team in determining level of risk that is based on information other than history of the condition. For example, if an individual has not had aspiration pneumonia in the past 6 months, they are often placed in a low risk category. Consideration is not given in the guidelines | |

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| | | that focus on factors resulting in an increased risk.<br><br>Another issue was that there was no screening that focuses on pneumonia risk. Aspiration/Choking is screened and this screening does contain some components of pneumonia risk identification but the issues leading to an increased risk of pneumonia and choking often varies, thus making a single "catch all" screening very difficult to be highly accurate.<br><br>There is an additional screening tool called the "Nutritional Management Risk Tool" that is used during the assessment phase or referral process. This screening tool is utilized to help the PNM team determine each individual's level of risk. Risk indicators were categorized across three levels: High (Level1), Medium (Level 2), and Low (Level 3).<br><br>The Nutritional Management Screening Tool was too narrow in focus and did not adequately include physical management aspects that may impact health status. Additionally, the NMT screening and the screening forms for aspiration and choking as well as other screening related to Physical and Nutritional Management (i.e., Constipation, GI issues, etc.) are not related to each other therefore resulting in increased fragmentation between areas of practice. Refer to provision O-2 for additional information.<br><br>Per sections J4 and J7, The Denton State Supported Living Center (DSSLC) used the Reiss screen for possible psychopathology across the campus, but the use of the screen was new. There was no information on whether information from this screen was used to identify risk. | |
| 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. | Health Status Team meetings appear to be the primary mechanism to achieve this interdisciplinary assessment of supports and services. HST meetings observed led the monitoring team to conclude the quality of discussion and team member interaction varies. In one HST meeting reports were given and there was very little discussion or interaction among team members. In another HST meeting there was quite a bit of discussion and interaction, however, the discussion did not delve into risk reduction to any extent and focused primarily on which of the three risk categories should be used for each individual was limited. Proactive, and substantive, discussion of risk mitigation did not occur in either meeting.<br><br>The HST meetings represent a good opportunity for team discussion on measures that can be taken to minimize risk. It appears little attention is given to this in the HST meetings. The Risk Assignment Tool used for assignment of risk level at HST meetings was reviewed. Items on that tool included both challenging behaviors and medical concerns like undiagnosed pain. These items had potential interest to the psychiatrist | |

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| | | and the broader behavioral healthcare team. It was not clear whether and how referrals for further behavioral health care evaluation were made for individuals assessed to be at risk by the Risk Assignment Tool. | |
| I3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring. | Refer to I1 | |

**Recommendations:**

1. There is a variety of clinical information available at DSSLC from which to identify individuals who are potentially at risk. The policies and procedures for a risk management system should draw together the various assessment instruments, other relevant information and procedures into one process that can reliably identify individuals whose health or well-being place them at risk and need special planning to mitigate risk. A process to bring this all together should include a review of each assessment tool to ensure they measure what is intended to be measured and criteria to assign risk levels is as objective as possible.
2. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. Therefore, DSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services.

| **SECTION J: Psychiatric Care and Services** | |
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| Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assure Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Policy and Procedures Reviewed:<br>Administrative 05 — Duty Officers: Physician and Administrative Services<br>Medical 01 — Medical Care Policy<br>Medical 03 — Transfer Information<br>Medical 04 — Guidelines for Admission to an Acute Care Facility<br>Medical 06 — Life Threatening Emergency Situation<br>Medical 07 — Death of an Individual who Resides at Denton SSLC<br>Medical 08 — Life Sustaining Treatment<br>Medical 09 — Guidelines for Acquiring Medical Care for Persons Served<br>Comm/Councils 03 — Behavior Support Review Committee (BSRC)<br>Comm/Councils 05 — Pharmacy and Therapeutics Committee (P&T C)<br>Comm/Councils 07A — Clinical Death Review Committee<br>Comm/Councils 07B — Administrative Death Review Committee<br>Comm/Councils 08 — Human Rights Committee (HRC)<br>Comm/Councils 09 — Pharmacy Consultation and Oversight Committee<br>Comm/Councils 11 — Infection Control Committee<br>Comm/Councils 22 — Investigative Medical Peer Review Committee<br>Client Mgmt 03A — Restraint<br>Client Mgmt 03B — Administration of Drug of Behavior Intervention<br>Client Mgmt 14 — At Risk Individuals – Health Status meetings<br>Client Mgmt 15 — Quality Enhancement Policy<br>Client Mgmt 16 — Psychotropic Medication – Prescription<br>Client Mgmt 20 — Limitation of Restraint as a Crisis Intervention<br>Client Mgmt 21 — Dental/Medical Sedation and Restraint<br>Division of Nursing — Medication Administration Policy<br><br>2. DADS 001 — Use of Restraint (08-31-09)<br>DADS 09-001 — Clinical Death Review (March 2009)<br>DADS 09-002 — Administrative Death Review (March 2009)<br><br>3. Comprehensive record review of the following individuals: Individual #67, #79, #90, #91, #127, #138, #151, #163, #222, #228, #229, #230, #236, #26, #5, #297, #306, #359, #373, #374, #393, #399, #413, #457, #482, #493, I #511, #512, #522, #539, #562, #579, # 629, #638, #659, #689, #681, #720, #766, #781.. Sections/document reviewed: Functional analysis, Comprehensive Diagnosis and Evaluation, BSRC reviews of PBSP, HRC review of PBSP, and Safety Plan for Crisis Intervention, Consent for Medication, most recent Medical Annual Review, most recent HST Quarterly Review, most recent MR Nursing Quarterly Assessment and Care Screening, most recent |

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| | monthly orders, Quarterly Drug Regime Review (QDRR) x 2, Psychiatry History and Exam, Psychiatric Assessment, Reiss Screen. All Psychiatric Treatment Reviews for most recent year, two most recent MOSES and DISCUS reviews. Most recent neurology consults, EEG, EKG; all seizure records and labs for the most recent year.<br>Partial reviews: complete records of chemical restraint, individual #399, #438, #359<br>4. Assessment tools reviewed:<br>DSSLC Medical Risk Assessment Tool (revised 10-27-09)<br>DSSLC Health Status Meeting Risk Assessment (revised 10-15-09)<br>DSSLC Restraint debriefing form<br>DSSLV Emergency use of psychoactive medication checklist<br>DSSLV Medical Record Audit (06-09-09); submitted by Punam Myer MD<br>5. Reports reviewed;<br>DSSLC Drug Order Report – use of Phenobarbital (23) and use of Mysoline<br>DSSLC FY 10 Allegations Trending Report<br>Tracking of psychiatric diagnosis changes<br>QA Audit form for June, July, August, Sep 2009 – Dr Punam Myer<br><br>**People Interviewed:**<br>1. John Beall, Ph.D., Chief Nurse Executive (CNE);<br>2. Rosha Chadwick, R.Ph., Pharmacy Director (two meetings);<br>3. Bryan Jacobs, LPN, Clinic Coordinator, Neurology Clinic;<br>4. Steven Kubala, M.D., Medical Director (two meetings);<br>5. Zourong Lin, M.D., Psychiatrist;<br>6. Julie Moy, M.D., DADS Medical Director (joined Dr Kuballa for second meeting);<br>7. Lori Powell, SA Coordinator;<br>8. Arifa Salam, M.D., Psychiatrist;<br>9. Satyajit Sathpathy, M.D., Psychiatrist:<br>10. Randi Spence, M.A., Director of Behavioral Services;<br>11. Lynn Wong, M.D., Consulting Neurologist.<br><br>Me**etings Attended/Observations:**<br>1. Locations visited: Infirmary, homes 509 and 510<br>2. Meetings attended:<br>a. PSP for Individual #138<br>b. Psychiatric Treatment Review (PTR) on 03-30-10; with Dr. Salam and Dr. Byrd, (Psychologist) PTR 03-31-10, with Dr. Lin, and Ms. McDonald-Wilt, ( Associate Psychologist).<br>c. HST meeting on 03-29-10, with Dr. Satpathy, Dr Mary Lee, (Primary Care Physician), and Ms. Criquette Tassin, (Associate Psychologist). Discussion at the meeting included reviews of individuals #236, #222, #562, #579 , #482 , #151, #49 , and #127<br>d. Neurology clinic on 03-31-10 with Dr. Wong, and with Mr. Bryan Jacobs, LVN, DSSLC specialty clinic coordinator,<br>e. Infirmary Medical Rounds on 03-30-10 |

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| | f. Meeting on 03-31-10 with Dr. Beal and DSSLC Nurse Managers.<br>g. BTRC Committee Meeting, on 03-31-10. |
| | **Facility Self-Assessment** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor Assessment:**<br><br>The psychiatry program at DSSLC was reviewed and its strengths were evident. Staff psychiatrists had appropriate training and credentials. Psychiatrists worked with colleagues from medicine and psychology in a collegial and respectful manner. DSSLC psychiatrists received strong support from other professional services. Pharmacy support was provided through day to day communication, through participation by pharmacists in healthcare team meetings, and through comprehensive QDDRs. DSSLC nurses were engaged meaningfully in the day-to-day behavioral health care and they collaborated as participants in multidisciplinary setting such as the HST meetings. Nurses also provided the required MOSES and DISCUS screenings medication side effects. Laboratory testing followed the requirements of the SA and HCG. Psychiatrists were involved meaningfully in quality assurance processes such as staff physician and monthly polypharmacy meetings. Psychiatrists were active participants in several clinical oversight committees, including the Psychiatric Care and Services Workgroup and the P&TC. The psychiatric program additionally benefitted from the efforts of the leadership at DSSLC to improve clinical flow-of-information. Results of these efforts have lead to improvements in multidisciplinary - and to some extent interdisciplinary – processes. This was evident, for example in the HST meetings. Efforts of DSSLC to improve psychiatric quality assurance were evident in the work of committees, including P&TC and Trends Analysis Committee (TAC). The Settlement Agreement (SA) Coordinator and others in the DSSLC leadership participated in local and statewide efforts to continue to improve both the HST and PSP processes.<br><br>The above strengths notwithstanding, the need for continued improvement was evident in a number of areas:<br><br>• SA item J2: Some reviews of "Not Otherwise Specified (NOS)" diagnoses lacked clarity regarding the grounds upon which the new diagnosis was selected.<br><br>• SA item J4: Psychiatrists at DSSLC were not involved in the process of evaluating individuals referred for pre-treatment sedation.<br><br>• SA item J7: The Reiss screen was in use at DSSLC as a tool that can identify individuals who might benefit from behavioral support services. The results of the screening process have not yet been fully integrated into routine clinical operations. The Director of Psychology provided assurances that the process to fully implement use of the Reiss screen is well underway.<br><br>• SA item J8: The SA mandated integration of pharmacological treatment with other interventions through combined assessment and case formulation. Case formulation for the purpose of pharmacotherapy remained, however, largely in the hands of psychiatry. |

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| | • SA item J9: The SA mandated a determination of whether individuals are best served primarily through behavioral pharmacological or other interventions, in combination or alone. In the PBSP documents there was no clear delineation of which behavioral symptoms were treated with behavioral, vs. pharmacological interventions. As a result, it was difficult to understand how treatments were selected.<br><br>• SA item J11: DSSLC monitored psychiatric polypharmacy in many ways. However, the monitoring focused on the presence or absence of polypharmacy and the kind of polypharmacy (e.g. interclass, intraclass) that it represented. Psychiatrists did not provide information on why the particular combinations of medications were appropriate for the care of each individual who was treated with polypharmacy<br><br>• SA itemJ13: The SA required that the treatment plans for psychotropic medications should provide needed details via which treatment efficacy will be determined. Many of these details were not articulated in the individual clinical records, either in the medication consent forms or the PBSP. The SA also required monitoring of the psychiatric treatment. There was little use of generally accepted observer rating tools for signs and symptoms of disorders like anxiety and depression. There needs to be an assessment of whether each medication is providing a benefit. The behavioral data presented at PTRs and other meetings, however, did not allow such assessments, since the same behavioral data was typically presented only for the overall psychotropic medication regimen.<br><br>• SA item J15: Anticonvulsants were often used for psychiatric indications, and many individuals at DSSLC had seizures. The pharmacy greatly assisted the process of keeping track of the reason that anticonvulsants were prescribed, by listing which anticonvulsants were prescribed for seizure management, which were prescribed for psychiatric purposes such as mood stabilization, and which were prescribed for both. While DSSLC psychiatrists made good use of this tracking system, there is some room for improvement. The presence of an on-site neurology clinic was a resource that facilitated good communication between DSSLC psychiatrists and the consulting neurologist around shared cases. While DSSLC psychiatrists generally made good use of this resource, there is some room for improvement.<br><br>In summary, the psychiatry program at DSSLC appeared to be strong in both clinical substance and process. A continued focus on overall interdisciplinary integration is advised, and attention to several specific areas is warranted, to assure compliance with SA requirements. |

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| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals. | DSLLC was budgeted for and employed three full time staff psychiatrists, Drs Lin, Satpathy and Salam. A fourth psychiatrist, Dr Harden, worked on a part time basis. The curriculum vitae, medical licenses, and specialty board certificates of the psychiatrists were reviewed. Dr Lin recently completed his training in psychiatry, and he was eligible | |

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| | | for board certification in psychiatry by the American Board of Psychiatry and Neurology. Drs. Satpathy and Salam had a decade of experience in psychiatry and Dr. Harden had several decades of experience in psychiatry. All three were board certified by the American Board of Psychiatry and Neurology. Drs. Harden, Salam, and Satpathy had considerable experience working with individuals with mental health needs and intellectual disabilities, but they did not have specific subspecialty training in the field of intellectual disability psychiatry. This is common in the field. All staff psychiatrists were interviewed. Dr. Hardin was not on site during the visit of the monitoring team and plans to interview him were deferred to the next scheduled tour. The Medical Director's overall supervision of the psychiatrists was reviewed. Over 200 individuals who live at DSSLC received some form of psychiatrist support. Accordingly, each full time psychiatrist carried a case load of about 60 -70 individuals. The job descriptions of the psychiatrists included direct responsibilities for the psychiatric diagnosis and management of the individuals under their care. Individuals were seen as needed, and in regularly scheduled PTRs. These reviews took place at least quarterly, and were conducted jointly with psychologists and other members of the HST. Psychiatrists were active in the interdisciplinary process. They participated in scheduled HST meetings lead by the Primary Care Physicians (PCP). Psychiatrists were members of the PST and attended meetings as required. Psychiatrists attended regularly scheduled physician staff meetings and they attended monthly psychopharmacology/polypharmacy meetings. Psychiatrists worked closely with members of the Pharmacy Department and reviewed QDRRs prepared by pharmacists. Psychiatrists reviewed DISCUS and MOSES screenings which had been completed by nurses. | |
| 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. | Records reviewed included psychiatric assessments, many of which were completed by the current team of psychiatrists. Charting typically included a discussion of the rationale for medication treatment. Psychotropic medications were reviewed as part of the QDRR. All diagnoses were made by trained psychiatrists. The diagnostic guidelines for the application of the Diagnostic and Statistical Manual (DSM IV TR) of the American Psychiatric Association is sometimes difficult to apply to individuals with significant intellectual disabilities. A recent advance in the field is the development of the Diagnostic Manual Intellectual Disability (DMID). Its development and deployment represents the first instance in which the American Psychiatric Association has endorsed a subspecialty manual. The DM-ID uses the same diagnostic categories as the DSM IV TR, and it provides diagnostic criteria for individuals who have both mental heath needs and an intellectual disability. The DM-ID further assists the diagnostic process, by making needed differentiations between individuals with higher vs. lower levels of intellectual function. The DMID was in use at DSSLC and its use will help maintain a consistent application of the DSM process to the individuals who live at the facility.<br><br>The use of Not Otherwise Specified (NOS) psychiatric diagnoses was more frequent at DSSLC than would be expected. At the time of the monitor's visit, DSSLC was in the | |

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| | | process of a review of psychiatric diagnoses, which focused on individuals who had a diagnosis from the NOS category. NOS diagnoses are often used when individuals do not meet criteria for more specific disorders. They are potentially problematic, since the requirements for the use of such diagnoses can be so permissive as to lack clarity about the nature of the underlying problem. For these reasons, the decision by DSSLC to review individuals who carried such diagnoses was wise.<br><br>In some diagnostic reviews, for example in the case of individual #67, the psychiatrist delineated both the reasons that the NOS diagnoses were removed and the reasons that other diagnoses were put in place. In other cases, for example that of individual # 393, such documentation was lacking: Individual #393 underwent a psychiatric (re) assessment in 2008. That individual had been previously diagnosed, amongst other things, with both a Mental Disorder NOS due to chronic encephalopathy secondary to history of seizure disorder, and also with Anxiety Disorder NOS. During 2008 the first diagnosis was removed and the latter was changed to Generalized Anxiety Disorder. It is reasonable to wonder whether generalized anxiety was initially avoided in favor of the NOS diagnosis, because the individual failed to meet criteria for the more specific disorder. Accordingly, a brief comment should have been included in the assessment specifying which of the required criteria for the diagnosis of generalized anxiety the client met. Such clarity would also have set up the parameters for the eventual treatment plan for medication.<br><br>Further attention will be needed to assure resolution of NOS diagnoses in a clinically credible manner. | |
| J3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment. | No examples were found in which medications were used for staff convenience or for punishment. As outlined elsewhere in this report, the monitoring teams found a lack of overall behavioral programming. In the area of psychiatry; PSPs addressed care only in very general terms. In the PSP for individual #539, substantive comments for psychiatric care were limited to observations that the individual took two medications to treat the symptoms of three psychiatric diagnoses, and that "Possible benefits...include(d) a reduction in psychiatric symptoms such as agitation and associated problems." The PSP also stated, without any accompanying details, that the benefits of the treatment outweighed the side effects. The PSP for individual #393 stated only that the individual had some psychiatric problems and was treated with two medications for depression. The PSP for individual #720 stated only that the individual should continue to take three prescribed psychotropic medications and should follow-up with the psychiatrist. The PSP for individual #67 stated only that the client received five medications for symptoms of his Axis I diagnosis, that the risk of physical aggression toward self and others outweighed the side effects of medication, and that he should follow-up with his psychiatrist to evaluate the efficacy of his current psychoactive medication. | |

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| | | In each of these PSPs, the information on medications lacked specificity as to specific behavioral targets for particular medications, there was no data by which to judge whether the treatments were effective, and the information on side effects was too general to be helpful. More generally, the psychiatric component(s) of the IHPs provided no information about the individuals' strengths and weaknesses, they did not contain measurable goals or treatment strategies and the sparse clinical information that was provided in the PSPs was not integrated with contributions from other clinical disciplines. As a result, the psychiatric component of the PSPs failed to contribute to an overall understanding of the individuals in question, and failed to clarify how continued psychiatric care would contribute to the individuals' abilities to live more independent and functional lives. | |
| 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. | The SA specified that pretreatment sedation should be coordinated with psychiatric services, as deemed appropriate for the individual. Psychiatrists at DSSLC were not involved in the process of evaluating individuals referred for pre-treatment sedation. | |
| J5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement. | DSSLC employs three full time psychiatrists and one part time psychiatrist, , with the expectation of case loads of 65-70 individual per full time psychiatrist. Given the level of complexity of the individuals supported, these are reasonable caseload expectations. | |

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| J6 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B. | DSSLC has experienced very substantial increases in available psychiatric time over the past several years. Psychiatric evaluations done since the increase in staffing were comprehensive, and the outline of psychiatric assessment was followed. This was the case for evaluations of individual # 67, individual #393 and individual #539. Not all of the components included in Appendix B of the SA were present in each case, however. For example, developmental and social history was listed as "none documented" in the assessment of individual # 539. | |
| 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. | The Reiss screen was in use at DSSLC for new admissions, and it was used to screen for psychopathology in individuals who live at DSSLC but do not receive routine psychiatric care. The monitoring team was provided with a list of individuals who live at DSSLC, who do not have a behavior plan in place, but in whom the results of the Reiss screen indicate a likelihood that the individual might benefit from mental health care. An attached letter addressed to DSSLC staff clarified that the PSTs of those individuals were encouraged to consider the needs of those individuals with the results of the Reiss screen in mind. This indicated that the process of screen and assessment is underway at DSSLC, but it is not yet complete. The monitoring team will review at the next visit whether the comprehensive functional assessment process includes review of the results of the Reiss Screen. The facility provided the monitoring team with five examples of evaluations of newly admitted individuals. These psychiatric assessments were in keeping with guidelines provided by SA appendix B. | |
| 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 | The integration of pharmacological treatments with behavioral and other interventions through combined assessment and case formulation was reviewed. Psychology and psychiatry staff worked side by side in PTR and HST meetings. Case formulation for the purpose of pharmacotherapy remained, however, largely in the hands of psychiatry. Behavioral data presented at these meetings reflected target behaviors identified in the PBSP. Nurses attended the HST meetings, and DISCUS and MOSES reviews were completed. Nurses did not routinely participate in the psychiatric reviews. Pharmacy was involved via the monthly polypharmacy review meeting, through the QDRR process, | |

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| | combined assessment and case formulation. | and through oversight committees, such as the P&TC . | |
| 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. | The determination of the particular modality or modalities of treatment that are most appropriate to support an individual's behavioral healthcare needs is a function in which the entire PST has a role, with a particular focus on psychiatry and psychology. Accordingly, the process of determination is part of the PBSP process, and it is reflected in the broader PSP process. The process by which modalities of treatment were selected was reviewed for individual #67, individual #393 and individual #593. PSPs contained broad statements that the individual had behavioral/psychiatric symptoms, and that the medication was required for those symptoms. In each case more detailed information was contained in the PBSP, and in the HRC review of the PBSP. The HRC reviews contained information about the psychiatric diagnoses and contained statements such as:<br><br>"Psychotropic medications are considered a necessary adjunct to this PSPB to address (the individual's) diagnosis, symptoms and associated behavior….. Clonidine, Risperdal, Buspar, Topamax and Depakote are necessary to address these disorders… Less restrictive supports (absence of psychiatric medication) have not been successful in the past in reducing… physical aggression toward others (PAO), verbally disruptive behavior (VDB) and Leaving Without Notice. His psychiatric treatment continues to be needed since his psychiatric condition has not been permanently resolved." (Individual #67).<br><br>"The PST recommends the continuation of a PBSP to behaviorally and psychopharmacologically address the symptoms of (the individual's) Axis I diagnosis as well as manage behavioral issues(s). (The individual) continues to exhibit maladaptive behavior of self injurious behavior (SIB) that could potentially result in major injury to self." (Individual #393).<br><br>"Some problem behaviors can be intense and have the potential to result in injury to (the individual) or others. Injuries have occurred in the past. In addition, the type of problem behavior that (the individual) exhibits can be quite disruptive and result in the loss of programming opportunities and social stigmatization. (The individual) is also prescribed psychoactive medication for psychiatric symptoms and associated behavior problems." (Individual #539).<br><br>In each case there was no clear delineation of the particular symptoms that were treated with behavioral, vs. pharmacological interventions. Statements were made about connections between psychiatric and broader behavioral symptoms, but such statements used only broad and general terms. Thus, the HRC review of the PBSP for individual #67 states: "(The individual's) psychiatric treatment has been therapeutically beneficial and successful in controlling his psychiatric symptoms and thus in controlling physical | |

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| | | aggression to others, verbally disruptive behavior, and leaving without notice." This statement is likely true, but without knowledge of the specific symptoms targeted by the psychiatric (presumably pharmacological) treatment, it is difficult to verify the accuracy of the statement in anything more than very general terms. | |
| J10 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications. | DSSLC did not use separate plans for the use of psychotropic medication. Rather, the medication component of the overall behavior support program was incorporated into the overall PBSP. PBSPs (for example, page 4/8 of the plan for individual #393, dated 08-13-09) included a "Risk vs. Risk" discussion which stated that the risk of the medication were considered and appeared to outweigh the (risks) of possible side effects of the medications. It was not possible to determine where deliberations about risks and benefits took place, nor were deliberations about alternative treatment strategies specifically noted. | |
| J11 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated. | DSSLC monitored psychiatric polypharmacy in many ways. Polypharmacy was identified by pharmacist in the QDRR, and it was discussed at HST meetings. The presence of polypharmacy was one of criteria used to assess risk. Individuals were considered to be at high risk if they received two or more medications from the same class, three or more medications from for the same diagnosis, or two or more medications with the same mode of action. Individuals were considered to be at medium risk if they received a total of nine or more medications. Monthly polypharmacy meetings were also held, and psychiatrist participated in those meetings. Polypharmacy was a focus of the P&TC. None of the reviews or reports of polypharmacy provided an explanation or clinical justification of the reason(s) why the individual received the particular polypharmacy regimen. Such a review is needed, both since the use of several psychotropics may be needed for good treatment, and because there may be different reasons for the selection of a particular combination of medications. | |
| J12 | Within six months of the Effective | Nurses attended HST meetings. Side effects were monitored with DISCUS screening for | |

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| | 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. | tardive dyskinesia. These were completed every three months per SA guidelines. MOSES screens for side effects were completed every six months. The system used for review of these documents by the psychiatrist (and PCP, in the case of MOSES) was unclear. It is possible that they are reviewed outside standard team meetings, but at least in the case of the DISCUS, it is probably best to do the review at that time of either the PTR or HST. Nurses, however, typically do not attend PTRs. This matter will be reviewed for clarity at the time of the next site visit. | |
| J13 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly. | The SA required that the treatment plans for psychotropic medications would provide an 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, and by whom, when, and how this monitoring will occur. Many of these details were not articulated in the individual clinical records, either in the medication consent forms or the BPSP.<br><br>The SA also required monitoring of the psychiatric treatment identified in the treatment plan, as often as needed, but no less often than quarterly. Psychotropic medication treatment progress was monitored primarily at PTRs, where individuals were seen in person and their behavioral data was reviewed by a core team which included the psychiatrist, psychologist, pharmacist, QMRP, and direct care staff. Reviews also took place at HST meetings, which were lead by primary care physicians. In the charts reviewed, the psychiatrists typically commented in some fashion on the efficacy of the psychotropic medications. Behavioral data reported at these meetings consisted largely (although certainly not entirely) of the individual's performance on targets for overall behavioral treatments. These typically included measures like physical aggression toward others (PAO), verbally disruptive behaviors (VDB), self-injurious behaviors (SIB), and physically disruptive behaviors (PDB). There was little use of generally accepted observer rating tools for signs and symptoms of disorders like anxiety and depression.<br><br>Behavioral data presented at PTRs and other meetings typically did not present data which was directly connected to the plan for a particular medication. Instead, the behavioral data presented at PTR and other meetings typically compared the individual's overall behavioral data with his/her overall psychotropic medication regime.<br><br>To improve the process, psychiatrists and psychologists should meet to explore what information the psychiatrists want to have presented to them at PTRs, in order to best fulfill the clinical mandates outlined in the SA. The psychiatrists should consider a format where up-to-date data about the individuals' behavior is presented in a template that displays the identified goals for that medication treatment. Standardized formats | |

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| | | and procedures for identifying and tracking information on signs, symptoms, and other essential information should be developed and implemented. | |
| 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. | Informed consent was obtained with the help of colleagues from the Psychology Department. Information was provided to the Human Right Committee (HRC) and the BSRC. The SA requires that consent documentation should include assurances that the LAR was provided adequate information about diagnosis, purpose of medication, expected benefits, possible side effects, amongst other things. At times, information provided was too general. For example, individual #67 was treated with five psychotropic medications: The consent form addressed the issue of medication side effects by stating: "Possible adverse side-effects of the prescribed medications are detailed in the pharmacy report." HRC review of the PBSP for the same individual lists all five medications and states "see Thompson Microdex Report for side effects". While a reference to comprehensive background information is helpful, the Legally Authorized Representative (LAR) for the individual should be presented with information on the most common side effects that might be expected for each separate medication. | |
| 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. | Anticonvulsants were often used for psychiatric indications, and many individuals at DSSLC had seizures. The pharmacy greatly assisted the process of keeping track of the reason that anticonvulsants were prescribed, by listing which anticonvulsants were prescribed for seizure management, which were prescribed for psychiatric purposes such as mood stabilization, and which were prescribed for both. While DSSLC psychiatrists made good use of this tracking system, there is some room for improvement. Per review in HCG IIIC1a3, these lists should be reviewed for completeness.<br><br>More generally, the monitor explored the overall communication between neurology and psychiatry services, for individuals who receive both neurological and psychiatric care. In the past year DSSLC has been able to reinstate a twice-monthly on-site neurology clinic, staffed by a consulting neurologist. The clinic is an obvious venue for good collegial interaction and discussion between the disciplines. In some cases, for example that of individual #297, there was evidence of good collegial interaction which resulted in the individual's epilepsy being managed with a single medication which was suitable for seizure management, and which was also psychiatrically beneficial. In that case, the result was that the individual was treated with one medication rather than two. In the case of individual # 127 optimal communication was not achieved, at least on one occasion witnessed by the monitor: The care of this individual was reviewed at an HST meeting, and during that meeting there was a detailed discussion regarding whether particular behaviors of concern witnessed at BSSLC were, or were not, manifestations of a seizure disorder. Information on those behaviors was not presented, however, to the | |

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| | | consulting neurologist during the individual's subsequent evaluation in the neurology clinic. | |

**Recommendations:**

1. Complete review of psychiatric diagnoses; when necessary clarify that DSM requirements for new diagnoses are met.
2. Psychiatrists and psychologists should meet to explore what information the psychiatrists want to have presented to them at PTRs. Standardized formats and procedures for identifying and tracking information on signs, symptoms, and other essential information should be developed and implemented.
3. Complete integration/use of the Reiss screen for new admissions and for assessment of pre-treatment sedation needs.
4. Review processes for combined case assessment and case formulation, via increased interdisciplinary participation.
5. Review practices for generating psychotropic medication plans and for subsequent monitoring of those plans, per SA requirements.
6. Review practices for tracking whether anticonvulsant medications are used for psychiatric and/or neurological indications.
7. Consider increased use of accepted observer rating tools in the process of clinical assessments, and in tracking of psychiatric treatments.
8. Consider periodic review/comment on the particulars of psychiatric polypharmacy, for individuals receiving such treatment.
9. Consider the manner in which psychiatrists should be involved in evaluation of individuals receiving pretreatment sedation.

| SECTION K: Psychological Care and Services | |
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| Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>Documents reviewed for the following individuals: #28, #91, #247, #337, #458, #591, #661, #669, #681, and #799, including the annual PSP, PSP updates, SPOs, PBSPs, 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, and behavioral and functional assessments.<br><br>**People Interviewed:**<br>1. Frank Padia – Director of Program Coordination<br>2. Randy Spence, MS – Chief Psychologist<br>3. Dora Tillis – Assistant Director of Programs<br>4. Linda Ford, Active Treatment Coordinator<br>5. Sheila Carpenter, Life Skills Coordinator<br>6. Luz Mendoza, Recreation Coordinator<br>7. Barbara Herndon, Vocational Training Coordinator<br>8. All Psychology Department staff<br>9. Zourong Lin, M.D., Psychiatrist<br>10. Satyajit Sathpathy, M.D., Psychiatrist<br>11. Anita Ezenberger – Building Coordinator (504)<br>12. Shenice Taylor – Building Coordinator (527)<br>13. Two DCPs (507)<br>14. DCP (504)<br>15. DCP (505)<br>16. Rehab Therapist (ICD121)<br>17. Rehab Therapist (ICD128)<br><br>**Meeting Attended/Observations:**<br>1. IRT – Eastfield<br>2. Psychiatric Clinic – 504, 522<br>3. PSP – 524<br>4. Observations of ICD workshops 121 and 128<br>5. Observations of meals, program implementation and leisure activities in residences 504, 505, 507, 509, 513, 514, 515, 522, 524, 527 & 528<br>**6.** Other individuals who were observed at living, recreation, and work sites include #20, #131, #141, #229, #304, #309, #381, #408, #504, #527, and #731. |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |

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| | **Summary of Monitor Assessment:**<br>During the initial site visit to DSSLC, an opportunity was provided to observe and document the status of behavior and training services at the facility. Various strengths were noted while conducting these observations. These strengths include the following.<br>• The employees who have earned board certification as a behavior analyst all displayed a well-developed set of professional skills and expertise. These individuals demonstrated a sound conceptualization of the tasks required to comply with the Settlement Agreement and will be a valuable asset in meeting those compliance issues.<br>• Both internal and external peer review is provided for the psychology staff. The process for internal peer review was noted to be thorough and reflected the properties of a good peer review process. The external peer review process, although noted to lack the robustness of the internal peer review, reflected a good initial effort and could serve as a foundation for further development.<br>• A good working relationship between the psychology and psychiatry staff was both reported by staff and observed. This allowed for an open exchange of ideas and was noted to facilitate the assessment and treatment development process.<br><br>In addition to the strengths noted here, a variety of issues were encountered during observations and record reviews that will require considerable remediation in order for DSSLC to meet the expectations of the Settlement Agreement.<br><br>A schism was noted to exist in the Psychology Department between the staff who have obtained the BCBA credential and those who have not. This schism primarily involved a perceived bias in favor of applied behavior analysis that was perceived by the staff without the BCBA as devaluing and demeaning. It was not evident from the comments provided by the staff without the BCBA that these staff members were familiar with the evidence supporting applied behavior analysis in the delivery of services to people with intellectual and developmental disabilities.<br><br>In addition to the professional schism between the staff with and without the BCBA, there was also a substantial difference between the two groups in the ability to conduct behavior assessments and develop sound behavior interventions. The staff members without the BCBA were less likely to have conducted a functional assessment of undesired behavior conforming to current accepted practices. This group was also more likely to have developed PBSPs that lacked the correct use of terminology, did not apply behavior change principles correctly, and did not reflect an empirical, evidence-based approach to treatment.<br><br>Regardless of whether a staff member possessed the BCBA or not, psychologists at DSSLC often did not conduct a thorough or timely assessment of mental illness, medical conditions, or physical issues in relation to undesired behavior. Similarly, psychological assessments commonly reported scores for adaptive behavior or intellectual assessments that were many years old. Such older scores are not likely to reflect the current abilities of people living at DSSLC and do not contribute to the treatment development process.<br><br>Significant limitations were also documented regarding the collection of treatment data, the value of those data that were collected and the manner in which data were used in determining the effectiveness of a |

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| | behavior intervention. In many cases, data were unlikely to be accurate because of the way behavior is documented, but no effort was made to measure how accurate those data might be. Treatment decisions often were not supported by the data available in the record and it was unclear what information was used in formulating such decisions.<br><br>Competence in applying behavioral principles was also lacking in staff members outside of the Psychology Department. Observations and interviews reflected that the majority of facility personnel lacked the skills to apply formal or informal behavior change strategies. In other situations, staff members acknowledged that they deviated from the procedures in PBSPs because of limited resources, time or skills. As a result, undesired behaviors were observed to continue without intervention or were inadvertently strengthened by inappropriate efforts by staff. At the time of the site visit, there was not a system to monitor the implementation of PBSPs or provide ongoing training to staff members regarding those PBSPs.<br><br>Although several strengths were noted during the site visit at DSSLC, the number and extent of noted limitations are reason for substantial concern. In many settings, individuals living at DSSLC are not provided with accurate and meaningful behavior assessment and intervention, allowing undesired behaviors to continue. As a result, these individuals are not provided with the opportunity to develop and enhance their independence or enjoy a reasonable quality of life. |

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| 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 | At the time of the site visit, DSSLC employed four individuals, three full-time and one contractual, each of whom is credentialed as a Board Certified Behavior Analyst. Additionally, these four individuals are assigned to the Behavior Services department where they function as consultants to the remainder of the psychology staff, as well as provide services to individuals with particularly difficult undesired behaviors, serve as the core members of the internal Peer Review Committee, and perform other duties relating to applied behavior analysis.<br><br>DSSLC also employed at the time of the site visit, 13 additional masters-level psychologists. These staff members were assigned to residences or specific service areas and were tasked with the delivery of psychological services to individuals living at the facility. Although some of these staff indicated experience in applied behavior analysis or the intent to pursue training in applied behavior analysis, none were credentialed as a Board Certified Behavior Analyst (BCBA).<br><br>The presence of four BCBAs at the facility, in addition to the Behavior Services director who is completing requirements for becoming a BCBA, was noted to be of substantial benefit. As is indicated in the sections below, PBSPs developed by the BCBA staff were substantially of greater sophistication. In addition, the BCBA staff allowed for internal peer review, the conducting of experimental analysis of behavior and an enhanced | |

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| | who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint. | application of an evidence-based approach to treatment.<br><br>Unfortunately, the availability of BCBAs introduced a substantial degree of tension and resentment between those staff who did not possess board certification and those who did. It was often expressed by the staff without board certification that too great an emphasis was placed upon applied behavior analysis, that the board certified personnel were over-valued and that the individuals living at the facility were not provided with a well-rounded approach to intervention because of this disparity.<br><br>In the majority of areas, as is reflected in the sections below, the concerns voiced by the non-BCBA staff could not be validated. The existence of these concerns amongst a large segment of the psychologists does reflect a substantial problem that DSSLC will need to address if the Settlement Agreement is to be completed successfully; all psychologists must recognize the value of evidence-based practice and applied behavior analysis, and develop skills in these areas.<br><br>In order to obtain a baseline measure of the delivery of psychological services, the Behavior Services department was requested to submit the records of 10 individuals whose assessments and interventions were considered to be among the best at DSSLC. Five of these cases were to be prepared by psychologists with a BCBA credential or advanced training in applied behavior analysis. The remaining five cases were to be those developed by psychologists without a BCBA credential or applied behavior analytic training. Details of these 10 PBSPs are presented in section K4 below.<br><br>The table below reflects the qualifications and credentials for those 10 psychologists who prepared the submitted cases.<br><br>Explanation of scores for tables:<br>Rating for each item in a table can be 0 (Not Successful), 1 (Partially Successful) or 2 (Fully Successful).<br>Each table below has a column called Average Score. The Average Score is the average of each sample item's or person's score on that item. The average can be from 0 to 2. A higher average score can show progress has been made meeting that item.<br><br>Each table also has a column for Percentage FS. The Percentage FS is the percentage of the people in the sample group who were rated as 2 (Fully Successful). A higher percentage shows that more people in the sample scored a 2 for that item.<br><br>An item with a higher Average Score can still have a low Percentage FS. This is because the two numbers show things in different ways. By comparing both numbers from site visit to site visit, progress can be measured in two different ways.<br><br>**Qualified professionals for PBSP** — **Average Score** — **Percent FS** | |

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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>
<table>
<tr><td>1</td><td colspan="2">PBSP developed by a BCBA (If less than FS, complete items below)</td><td>0.80</td><td>40.0%</td></tr>
<tr><td></td><td>a.</td><td>Completed by BCABA with BCBA supervision (Y or N)</td><td>0.00</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>Completed by professional enrolled in BCBA certification program (Y or N)</td><td>0.33</td><td>100.0%</td></tr>
<tr><td></td><td>c.</td><td>Completed by professional with demonstrated competence (Y or N)</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>2</td><td colspan="2">A plan/policy exists with a goal to increase the number of professionals who possess board certification in applied behavior analysis through training, recruitment or other means.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td>3</td><td colspan="2">The plan/policy above is being actively implemented.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td>4</td><td colspan="2">A process exists for auditing credentials of those staff members who possess board certification in applied behavior analysis.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td>5</td><td colspan="2">The PBSP promotes growth, development, and independence; and minimizes regression and loss of skills; and ensures safety, security and freedom from undue restraints</td><td>1.00</td><td>0.0%</td></tr>
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<br>Of particular note in regard to plans for increasing the number of staff with board certification was the availability of funds for enrolling in classes required for board certification. At the time of the site visit, funds were available from DADS to reimburse staff for tuition and fees after completing the BCBA classes. Due to the relatively high cost of the classes, many psychologists at DSSLC indicated that they could not afford to take the classes and then wait for reimbursement.
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<tr><td>K2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.</td><td>At the time of the site visit, DSSLC employed a full-time director of Behavior Services, Joseph Randall Spence. Mr. Spence has extensive experience in the field of intellectual and developmental disabilities. Although Mr. Spence is not a licensed psychologist, his training and experience qualify him for this position. At the time of the site visit, he was actively involved in taking courses and obtaining supervision in order to earn board certification as a behavior analyst. When he has earned board certification, his role as director of Behavior Services will be in full compliance.</td><td></td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K3</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.</td><td>
DSSLC, at the time of the site visit, maintained an active internal peer review committee. This committee is coordinated by the Behavior Services staff members that are board certified as behavior analysts. Observations of a committee meeting, as well as a review of committee minutes and discussion with staff, revealed active application of a sound peer review model.
<table>
<tr><th></th><th colspan="2">Peer review system of PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">Internal Peer Review</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>a.</td><td>A policy for internal peer review exists.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>b.</td><td>Membership of internal peer review meetings consists of PBSP authors and those that supervise implementation of plans.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>c.</td><td>Minutes demonstrate occurrence of weekly peer review meetings.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>d.</td><td>Observations of meetings reflect active member participation and data-based decisions.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>e.</td><td>Individuals with PBSPs are reviewed at least annually.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>f.</td><td>Individuals with Safety Plans are reviewed at least annually.</td><td>2.00</td><td>100.0%</td></tr>
</table>
In terms of obtaining external peer review, DSSLC has initiated a contract with a psychologist external to the facility who is board certified in behavior analysis. A review of minutes of the external review as well as discussion with staff indicates that the current arrangement is a good first step. Relying upon a single individual for external peer review does not offer a broad base of experience and expertise. In addition, a single external review person can lead to backlogs in review and approval should the person in question be unavailable. In order to meet the requirements of the Settlement Agreement, it will be advisable for DSSLC to expand and enhance the external peer review process.
<table>
<tr><th></th><th colspan="2">Peer review system of PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>2</td><td colspan="2">External Peer Review</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>A policy for external peer review exists.</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>b.</td><td>Membership of external peer review meetings consists of other Texas State BCBAs/supervisors.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Minutes demonstrate occurrence of monthly peer review meetings.</td><td>2.00</td><td>100.0%</td></tr>
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</td><td></td></tr>
<tr><td>K4</td><td>Commencing within six months</td><td>Considerable deficits were noted in the collection of behavior data at the time of the site visit. In the majority of records reviewed, there was reliance upon total frequency counts across periods of several hours. Such</td><td></td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not</td><td>data collection practices do not provide valid and reliable data under the best of conditions. Conversations with direct care staff indicated that the typical environment in a residence, class room or vocational setting lacks the number of staff and technical resources necessary for data collection. As a result, behaviors often go unrecorded or are reported as a best guess at the end of the hours-long interval. Therefore, if total frequency counts were in fact the best type of data for a given behavior, the conditions would not typically allow for adequate data to be collected.<br><br>More sophisticated yet ultimately more efficient data collection procedures were seldom described by staff or included in PBSPs. If DSSLC is to satisfy the settlement agreement, increased use of interval, time sampling, permanent product and other data collection strategies will be necessary.<br><br>Even though most psychologists and other staff acknowledged substantial weaknesses in behavior data, there was not any routine assessment of the actual quality of those data. Except in isolated cases that were verbally reported, there was no attempt to measure data reliability and interobserver agreement (IOA).<br><br>The Behavior Services department at DSSLC uses spreadsheet software to compile treatment data and generate data graphs and progress notes. Although the data entered into this software are of questionable value, the software itself is sophisticated and useful. Most elements required in a data graph are present and the graphs are not overly complex. There existed some weaknesses that limit the benefit of the data graphs in monitoring treatment progress. One of these weaknesses was that frequent updates have led to inconsistencies in the elements of the spreadsheet package, such as where a specific tab is located or if it is in fact included. While not a major weakness, it can lead to confusion. A greater weakness seen across all reviewed graphs was a lack of any indicators for changes relevant to monitoring behavioral progress. For example, if the dosage of a medication was changed or the individual was exposed to an environmental stressor, there was no indication on the graph of when the event occurred. Without such indicators, it is very difficult to easily identify the relationship between behavior, treatment effects and confounding variables.<br><br>As a result of the issues presented above, it is not possible in the majority of cases to determine whether a PBSP or psychotropic medication is providing any benefit to the individual or even if it is causing harm. Substantial changes in data collection practices, as well as environmental resources and conditions, will be necessary for DSSLC to make progress toward meeting this portion of the Settlement Agreement.<br><br>
<table>
<tr><th></th><th colspan="2">Data and monitoring progress of PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">A standard methodology exists for data collection that conforms to ABA generally accepted professional standards (All items below must be FS for this to be scored FS)</td><td>0.60</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>Targeted behavior data collection sufficient to assess progress.</td><td>0.50</td><td>0.0%</td></tr>
<tr><td></td><td>b.</td><td>Replacement behavior data collection sufficient to assess progress.</td><td>0.60</td><td>0.0%</td></tr>
<tr><td></td><td>c.</td><td>Data reliability is assessed.</td><td>0.00</td><td>0.0%</td></tr>
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| # | Provision | Assessment of Status | Compliance |
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improve or have substantially changed.

| | | | | |
|---|---|---|---|---|
| | d. | Target behaviors analyzed individually. | 1.20 | 60.0% |
| | e. | Targeted behaviors graphed sufficient for decision-making. | 0.60 | 0.0% |
| | f. | Replacement behaviors graphed sufficient for decision-making. | 0.60 | 0.0% |

Despite substantial limitations in the quality of behavior data, there is effort to make good use of what data are available. At the time of the site visit, data for virtually all individuals were reviewed on a monthly basis to determine treatment effects. In many cases, this review involved a BCBA and included input from one or more direct contact staff. Had the data been valid and reliable, such a process has the potential to produce sound treatment decisions.

In practice, DSSLC made poor use of the PBSP monitoring efforts. In only about half of the 10 records reviewed were treatment decisions supported by available data. Decisions contrary to available data included the decisions to continue treatment after the undesired behavior did not respond or accelerated, as well as the decision to introduce new treatment elements because it was time for the annual PSP. Several PBSPs did not specify the criteria for how a treatment would be determined as beneficial, making treatment decisions even less objective and data driven.

| | Data and monitoring progress of PBSPs | | Average Score | Percent FS |
|---|---|---|---|---|
| 2 | A standard methodology exists for monitoring and review of progress of PBSP (All items below must be FS for this to be scored FS) | | 1.50 | 50.0% |
| | a. | Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level. | 2.00 | 100.0% |
| | b. | Review is conducted by a BCBA. | 1.70 | 70.0% |
| | c. | Input from direct care staff is solicited and documented. | 1.60 | 60.0% |
| | d. | Modifications to the PBSP reflect data-based decisions. | 1.00 | 50.0% |
| | e. | Criteria for revision are included in the PBSP. | 1.20 | 60.0% |
| | f. | Progress evident, or program modified in timely manner (3 Months). | 0.70 | 30.0% |

The use of data and the monitoring of PBSPs was one of the areas in which differences in staff training, experience and credentials was pronounced. The table below compares the five "best example" records from non-BCBA psychologists with five "best example" records from BCBA psychologists. For every item other than monthly review of data graphs, the board certified behavior analysts outperformed their colleagues without board certification by a considerable margin. For some items, such a 1a through 1c, neither group approached full success in complying with that element of the Settlement Agreement. Even in those cases, the average scores of the BCBAs were substantially higher. Such differences emphasize the need to train staff and achieve parity across all psychology staff.

| # | Provision | Assessment of Status | Compliance |
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| | Data and monitoring progress of PBSPs | Non-BCBA | | BCBA | | Difference | |
|---|---|---|---|---|---|---|---|
| | | Average Score | Percent FS | Average Score | Percent FS | Average Score | Percent FS |
| 1 | A standard methodology exists for data collection that conforms to ABA generally accepted professional standards (All items below must be FS for this to be scored FS) | 0.20 | 0.0% | 1.00 | 0.0% | 0.80 | 0% |
| a. | Targeted behavior data collection sufficient to assess progress. | 0.20 | 0.0% | 0.80 | 0.0% | 0.60 | 0% |
| b. | Replacement behavior data collection sufficient to assess progress. | 0.40 | 0.0% | 0.80 | 0.0% | 0.40 | 0% |
| c. | Data reliability is assessed. | 0.00 | 0.0% | 0.00 | 0.0% | 0.00 | 0% |
| d. | Target behaviors analyzed individually. | 0.40 | 20.0% | 2.00 | 100.0% | 1.60 | 80% |
| e. | Targeted behaviors graphed sufficient for decision-making. | 0.20 | 0.0% | 1.00 | 0.0% | 0.80 | 0% |
| f. | Replacement behaviors graphed sufficient for decision-making. | 0.20 | 0.0% | 1.00 | 0.0% | 0.80 | 0% |
| 2 | A standard methodology exists for monitoring and review of progress of PBSP (All items below must be FS for this to be scored FS) | 1.20 | 20.0% | 1.80 | 80.0% | 0.60 | 60% |
| a. | Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level. | 2.00 | 100.0% | 2.00 | 100.0% | 0.00 | 0% |
| b. | Review is conducted by a BCBA. | 1.40 | 40.0% | 2.00 | 100.0% | 0.60 | 60% |
| c. | Input from direct care staff is solicited and documented. | 1.20 | 20.0% | 2.00 | 100.0% | 0.80 | 80% |
| d. | Modifications to the PBSP reflect data-based decisions. | 0.40 | 20.0% | 1.60 | 80.0% | 1.20 | 60% |
| e. | Criteria for revision are included in the PBSP. | 0.40 | 20.0% | 2.00 | 100.0% | 1.60 | 80% |
| f. | Progress evident, or program modified in timely manner (3 Months). | 0.00 | 0.0% | 1.40 | 60.0% | 1.40 | 60% |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>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>
The table below reflects ratings of psychological assessment procedures from 10 “best example” records. Among these 10 records there was substantial inconsistency in terms of the types of information reviewed, the age of that information and the likelihood of the provided information being valid. Overall, a minority percentage of the reviewed records included a formal assessment of adaptive behavior within the previous 12 months, an intellectual assessment within the previous 7 years, a formal assessment of psychopathology based upon an objective instrument or rating scale, or a review of biological, physical and medical conditions beyond a listing of symptoms or diagnoses. Because these assessments are not current, they may not provide information that is meaningful and contributes to the development of an individualized set of training programs. Long durations between assessments suggest that assessment results are not adequately considered in the development of teaching programs or the identification of individual needs.<br><br>
In order to develop effective interventions and teaching programs, psychological assessments must be comprehensive, rigorous and current. The majority of records reviewed are unlikely to contribute information about the individual that will be useful in developing teaching programs or PBSPs. It will be necessary for DSSLC to greatly expand the skills, tools and procedures relating to psychological assessments.<br><br>
<table>
<tr><th></th><th colspan="2">Standard psychological assessment procedures</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td colspan="2">Individual’s record includes a psychological assessment that at a minimum contains the following. (All items below must be FS for this to be scored FS)</td><td>0.80</td><td>0.0%</td></tr>
<tr><td></td><td>a.</td><td>Standardized assessment or review of intellectual and cognitive ability.</td><td>0.70</td><td>20.0%</td></tr>
<tr><td></td><td>b.</td><td>Standardized assessment of adaptive ability.</td><td>0.80</td><td>30.0%</td></tr>
<tr><td></td><td>c.</td><td>Screening for psychopathology, emotional and behavioral issues.</td><td>0.70</td><td>30.0%</td></tr>
<tr><td></td><td>d.</td><td>Assessment or review of biological, physical and medical status.</td><td>0.60</td><td>0.0%</td></tr>
<tr><td></td><td>e.</td><td>Review of personal history.</td><td>1.80</td><td>90.0%</td></tr>
</table>
<br>
Again a disparity is evident between BCBA and non-BCBA staff. In regard to standard psychological assessments, it is the non-BCBA staff who outperform in a variety of areas. The overall ratings for psychological evaluations, as well as ratings for the review of personal history and – especially – screening for psychopathology are substantially higher for non-BCBA staff.<br><br>
Current research strongly emphasizes the efficacy and importance of applied behavior analysis in working with individuals diagnosed with intellectual and developmental disorders. One underlying strength of applied behavior analysis is the reliance upon an objective and empirical process. Although this is a core element of applied behavior analysis, an objective and empirical approach to treatment can be applied within a number of different therapeutic contexts and perspectives. If all staff are not prepared to obtain and interpret valid and reliable data from all sources and pertaining to all areas, then the quality of interventions
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| # | Provision | Assessment of Status | Compliance |
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will be impaired. DSSLC must take steps to ensure that staff possesses all the skills they will need to provide services to the people living at the facility.

| | Standard psychological assessment procedures | Non-BCBA | | BCBA | | Difference | |
|---|---|---|---|---|---|---|---|
| | | Average Score | Percent FS | Average Score | Percent FS | Average Score | Percent FS |
| 1 | Individual's record includes a psychological assessment that at a minimum contains the following. (All items below must be FS for this to be scored FS) | 1.00 | 0.0% | 0.60 | 0.0% | (0.40) | 0% |
| a. | Standardized assessment or review of intellectual and cognitive ability. | 0.60 | 0.0% | 0.80 | 40.0% | 0.20 | 40% |
| b. | Standardized assessment of adaptive ability. | 0.80 | 20.0% | 0.80 | 40.0% | 0.00 | 20% |
| c. | Screening for psychopathology, emotional and behavioral issues. | 1.20 | 60.0% | 0.20 | 0.0% | (1.00) | -60% |
| d. | Assessment or review of biological, physical and medical status. | 0.60 | 0.0% | 0.60 | 0.0% | 0.00 | 0% |
| e. | Review of personal history. | 2.00 | 100.0% | 1.60 | 80.0% | (0.40) | -20% |

The table below reflects ratings of psychological assessment procedures from 10 "best example" records in regard to functional assessment of behavior. A number of strong functional assessments were included in the records submitted for review. The strengths noted differed considerably from one psychologist to the next. As a result of this lack of consistency, only 2 of the 10 functional assessments reviewed would meet the requirements of the Settlement Agreement. Furthermore, as a functional assessment is essential to the development of a PBSP, the current ratings indicate that few of the PBSPs at DSSLC are based upon sound assessments of behavior. It is therefore unlikely that the PBSPs at DSSLC will produce meaningful changes in behavior and that the individuals living at DSSLC will experience an improvement in quality of life or independence.

| | Standard psychological assessment procedures | Average Score | Percent FS |
|---|---|---|---|
| 2 | If the individual's record or assessments reflect behavioral disturbance or psychopathology, a functional assessment that includes the following is incorporated into the standard psychological assessment. (All items below must be FS for this to be scored FS) | 1.00 | 20.0% |

| # | Provision | Assessment of Status | | | | | Compliance |
|---|---|---|---|---|---|---|---|
| | | | a. | A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis. | 1.30 | 50.0% | |
| | | | b. | Differentiation between learned and biologically based behaviors. | 0.90 | 30.0% | |
| | | | c. | Identification of setting events and motivating operations relevant to the undesired behavior. | 1.30 | 50.0% | |
| | | | d. | Identification of antecedents relevant to the undesired behavior. | 1.30 | 50.0% | |
| | | | e. | Identification of consequences relevant to the undesired behavior. | 1.30 | 50.0% | |
| | | | f. | Identification of functions relevant to the undesired behavior. | 1.30 | 50.0% | |
| | | | g. | Identification of functionally equivalent replacement behaviors relevant to the undesired behavior. | 1.10 | 40.0% | |
| | | | h. | Identification of preferences and reinforcers. | 1.30 | 50.0% | |
| | | 3 | The functional assessment is reviewed when the Individual does not meet treatment expectations and is revised as needed with a maximum of one year between reviews. | | 1.00 | 40.0% | |
| | | 4 | If the individual's record or assessments reflect behavioral disturbance or psychopathology, assessment of possible psychopathology that includes the following is incorporated into the standard psychological assessment. (All items below must be FS for this to be scored FS) | | 0.20 | 0.0% | |
| | | | a. | Identification of behavioral indices of psychopathology | 0.80 | 30.0% | |
| | | | b. | Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities | 0.00 | 0.0% | |

A review of the differences in ratings between the BCBA and non-BCBA regarding functional assessment reveals important issues that DSSLC will need to address in order to comply with the Settlement Agreement. First, as indicated by the table below, the ability of non-BCBA psychologists to apply and interpret a functional assessment must be strengthened considerably. The non-BCBA psychologists displayed weaknesses across all elements relating to functional assessment. Part of this is due to a lack of experience and training. Another contributing factor is likely to be the lack of formal tools to structure and guide the functional assessment process. The BCBA psychologists often rely upon sophisticated assessment methods that are more informal. Without additional training and experience, the non-BCBAs lack the ability to approach behavior assessment in that manner. Obtaining and using formal tools would be of great benefit to these staff.

Although generally strong, the BCBA psychologists did display weaknesses that substantially limited their functional assessments. Some of these psychologists were less adept at identifying biological factors relating to an undesired behavior. Other BCBA psychologists experienced difficulty in selecting replacement behaviors that were functionally related to the undesired behavior they were attempting to reduce. Finally,

| # | Provision | Assessment of Status | Compliance |
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the BCBA psychologists, as well as their colleagues without board certification, often failed to review and/or revise a functional assessment when a PBSP on which it was based proved to be unsuccessful.

All of these issues again stress the necessity of increasing staff expertise within Behavior Services. In addition, DSSLC must make a better effort at quality assurance in regard to the elements of psychological and functional assessments.

| | Standard psychological assessment procedures | Non-BCBA | | BCBA | | Difference | |
|---|---|---|---|---|---|---|---|
| | | Average Score | Percent FS | Average Score | Percent FS | Average Score | Percent FS |
| 2 | If the individual's record or assessments reflect behavioral disturbance or psychopathology, a functional assessment that includes the following is incorporated into the standard psychological assessment. (All items below must be FS for this to be scored FS) | 0.60 | 0.0% | 1.40 | 40.0% | 0.80 | 40% |
| | a. A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis. | 0.80 | 20.0% | 1.80 | 80.0% | 1.00 | 60% |
| | b. Differentiation between learned and biologically based behaviors. | 0.40 | 0.0% | 1.40 | 60.0% | 1.00 | 60% |
| | c. Identification of setting events and motivating operations relevant to the undesired behavior. | 0.60 | 0.0% | 2.00 | 100.0% | 1.40 | 100% |
| | d. Identification of antecedents relevant to the undesired behavior. | 0.60 | 0.0% | 2.00 | 100.0% | 1.40 | 100% |
| | e. Identification of consequences relevant to the undesired behavior. | 0.60 | 0.0% | 2.00 | 100.0% | 1.40 | 100% |
| | f. Identification of functions relevant to the undesired behavior. | 0.60 | 0.0% | 2.00 | 100.0% | 1.40 | 100% |
| | g. Identification of functionally equivalent replacement behaviors relevant to the undesired behavior. | 0.60 | 0.0% | 1.60 | 80.0% | 1.00 | 80% |
| | h. Identification of preferences and reinforcers. | 0.60 | 0.0% | 2.00 | 100.0% | 1.40 | 100% |

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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>
<table>
<tr><td>3</td><td>The functional assessment is reviewed when the Individual does not meet treatment expectations and is revised as needed with a maximum of one year between reviews.</td><td>0.60</td><td>20.0%</td><td>1.40</td><td>60.0%</td><td>0.80</td><td>40%</td></tr>
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<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>
The table below reflects ratings of clinical data and psychological assessment for 10 “best example” cases provided by the Behavior Services at DSSLC. The issues relating to these ratings are discussed in the section immediately above.
<table>
<tr><th></th><th>Psychological assessments based on clinical data</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td>Individual’s records demonstrate that the assessment is based on</td><td>0.50</td><td>10.0%</td></tr>
<tr><td></td><td>• Current,</td><td>0.30</td><td>10.0%</td></tr>
<tr><td></td><td>• Accurate, and</td><td>0.40</td><td>10.0%</td></tr>
<tr><td></td><td>• Complete clinical and behavioral data.</td><td>0.60</td><td>20.0%</td></tr>
</table>
</td><td></td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual’s admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual</td><td>
The table below reflects ratings of psychological assessments for 10 “best example” cases provided by the Behavior Services at DSSLC. These ratings reflect that DSSLC is successful at ensuring a psychological assessment report is completed for each individual on an annual basis.
<table>
<tr><th></th><th>Psychological assessments completed for every individual</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td>Individual records demonstrate that these psychological assessments are conducted as often as needed, and at least annually, for each individual.</td><td>1.90</td><td>90.0%</td></tr>
<tr><td>2</td><td>For newly admitted individuals, psychological assessments are conducted within one month.</td><td>2.00</td><td>100.0%</td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td></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>A review of submitted records and discussions with staff reflected a small number of "counseling" programs at DSSLC, only two of which that have been developed within the past 18 months. There was a general lack of an empirical, evidence-based process in the counseling programs. The limited number of current interventions did not allow for an adequate review. DSSLC needs to develop standards and procedures to identify when such services are appropriate, how they will be provided, what curricula or standard therapeutic procedures will be used, how fidelity of implementing those procedures by clinicians will be assessed, and how treatment effectiveness will be evaluated.</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</td><td>As reflected in the table below, DSSLC is typically successful in obtaining the necessary consents and approvals for behavioral interventions in a timely manner.<br><br><table><tr><th></th><th>PBSP consent and initial implementation</th><th>Average Score</th><th>Percent FS</th></tr><tr><td>1</td><td>Necessary consents and approvals are obtained for each PBSP and safety plan prior to implementation.</td><td>2.00</td><td>100.0%</td></tr><tr><td>2</td><td>Within 14 days of obtaining consents the PBSP or safety plan will be implemented.</td><td>2.00</td><td>100.0%</td></tr></table><br>Although consents and approvals are routinely obtained in a timely manner, the PBSPs for which consent and approval were obtained were often lacking in a variety of areas. These problem areas include issues relating to the quality of the assessments (consideration of medical, psychiatric, and healthcare issues), as</td><td></td></tr>
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| # | Provision | Assessment of Status | Compliance |
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| | 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. | well as general knowledge of applied behavior analysis and the principles of learning (positive reinforcement and operational definitions). The table below presents overall ratings for 10 "best example" records provided by the Behavior Services department at DSSLC. | |

| | PBSP consent and initial implementation | | Average Score | Percent FS |
|---|---|---|---|---|
| 4 | The PBSP for which consent was obtained conforms to current best practices in applied behavior analysis. (All items below must be FS for this to be scored FS) | | 1.00 | 10.0% |
| | a. | Rationale for selection of the proposed intervention. | 1.40 | 50.0% |
| | b. | History of prior intervention strategies and outcomes. | 1.70 | 80.0% |
| | c. | Consideration of medical, psychiatric and healthcare issues. | 0.90 | 10.0% |
| | d. | Operational definitions of target behaviors. | 0.70 | 0.0% |
| | e. | Operational definitions of replacement behaviors. | 1.00 | 30.0% |
| | f. | Description of potential function(s) of behavior. | 1.30 | 50.0% |
| | g. | Use of positive reinforcement sufficient for the strengthening of desired behavior. | 0.90 | 40.0% |
| | h. | Strategies addressing setting event and motivating operation issues. | 1.20 | 50.0% |
| | i. | Strategies addressing antecedent issues. | 1.10 | 50.0% |
| | j. | Strategies that include the teaching of desired replacement behaviors. | 0.90 | 40.0% |
| | k. | Strategies to weaken undesired behavior. | 1.10 | 50.0% |
| | l. | Description of data collection procedures. | 0.90 | 30.0% |
| | m. | Baseline or comparison data. | 1.90 | 90.0% |
| | n. | Treatment expectations and timeframes written in objective, observable, and measureable terms. | 1.60 | 70.0% |
| | o. | Clear, simple, precise interventions for responding to the behavior when it occurs. | 1.00 | 30.0% |
| | p. | Signature of individual responsible for developing the PBSP. | N/A | N/A |
| 5 | Evidence that the intervention is based on functional assessment results, individual preferences, and on-going individual behavior. | | 0.80 | 30.0% |

As indicated in previous sections, there was substantial disparity between the board certified behavior analysts and those without board certification. As ratings of the two groups are reflected in the table below, neither of the two demonstrated mastery of fully developing and implementing a behavioral intervention. This is of particular concern as the PBSP reflects the knowledge and skill set of the psychologist and is more isolated from limitations in resources and the environment than are assessment or data collection. These

| # | Provision | Assessment of Status | Compliance |
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ratings therefore indicate that all psychologists have substantial limitations relating to the ability to develop a PBSP.

In order to meet the conditions of the Settlement Agreement, it will be essential that DSSLC develop and implement both a training curriculum for the Behavior Services staff, as well as a process for monitoring the application of basic behavioral skills.

| | PBSP consent and initial implementation | | Non-BCBA | | BCBA | | Difference | |
|---|---|---|---|---|---|---|---|---|
| | | | Average Score | Percent FS | Average Score | Percent FS | Average Score | Percent FS |
| 4 | The PBSP for which consent was obtained conforms to current best practices in applied behavior analysis. (All items below must be FS for this to be scored FS) | | 0.80 | 0.0% | 1.20 | 20.0% | 0.40 | 20% |
| | a. | Rationale for selection of the proposed intervention. | 0.80 | 0.0% | 2.00 | 100.0% | 1.20 | 100% |
| | b. | History of prior intervention strategies and outcomes. | 1.60 | 80.0% | 1.80 | 80.0% | 0.20 | 0% |
| | c. | Consideration of medical, psychiatric and healthcare issues. | 0.60 | 0.0% | 1.20 | 20.0% | 0.60 | 20% |
| | d. | Operational definitions of target behaviors. | 0.40 | 0.0% | 1.00 | 0.0% | 0.60 | 0% |
| | e. | Operational definitions of replacement behaviors. | 0.60 | 20.0% | 1.40 | 40.0% | 0.80 | 20% |
| | f. | Description of potential function(s) of behavior. | 0.60 | 0.0% | 2.00 | 100.0% | 1.40 | 100% |
| | g. | Use of positive reinforcement sufficient for the strengthening of desired behavior. | 0.20 | 0.0% | 1.60 | 80.0% | 1.40 | 80% |
| | h. | Strategies addressing setting event and motivating operation issues. | 0.40 | 0.0% | 2.00 | 100.0% | 1.60 | 100% |
| | i. | Strategies addressing antecedent issues. | 0.20 | 0.0% | 2.00 | 100.0% | 1.80 | 100% |
| | j. | Strategies that include the teaching of desired replacement behaviors. | 0.20 | 0.0% | 1.60 | 80.0% | 1.40 | 80% |
| | k. | Strategies to weaken undesired behavior. | 0.20 | 0.0% | 2.00 | 100.0% | 1.80 | 100% |
| | l. | Description of data collection | 0.20 | 0.0% | 1.60 | 60.0% | 1.40 | 60% |

| # | Provision | Assessment of Status | Compliance |
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|---|---|---|---|---|---|---|---|---|---|
| | | | procedures. | | | | | | |
| | | m. | Baseline or comparison data. | 2.00 | 100.0% | 1.80 | 80.0% | (0.20) | -20% |
| | | n. | Treatment expectations and timeframes written in objective, observable, and measureable terms. | 1.20 | 40.0% | 2.00 | 100.0% | 0.80 | 60% |
| | | o. | Clear, simple, precise interventions for responding to the behavior when it occurs. | 0.60 | 20.0% | 1.40 | 40.0% | 0.80 | 20% |
| | 5 | Evidence that the intervention is based on functional assessment results, individual preferences, and on-going individual behavior. | | 0.20 | 0.0% | 1.40 | 60.0% | 1.20 | 60% |

K10 Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions,

The table below presents ratings of graphs and data integrity for 10 "best example" cases submitted by the Behavior Services department at DSSLC. As discussed previously, the reliability of behavior data is not typically measured at DSSLC. Although data collection procedures generally lack the sophistication to provide meaningful and robust data, the lack of reliability measures does not permit accurate evaluation of the efficacy of treatment. It is possible that, despite limitations in the data collection process, the data for some behaviors such as high intensity and low frequency screaming could be reliable. Without attempts to determine reliability, the reliability remains unknown and therefore does not provide meaningful information about the behavior of the individual.

In order to meet the Settlement Agreement, DSSLC must develop better ways to collect behavior data. At the same time, there must be a substantial effort to implement a system of measuring the reliability of those data. Without such a system, all data will remain questionable.

| | | | PBSP implementation and documentation | Average Score | Percent FS |
|---|---|---|---|---|---|
| | 1 | Inter-observer agreement exists for PBSP data (All items below must be FS for this to be scored FS). | | 0.00 | 0.0% |
| | | a. | IOA for target behavior data. | 0.00 | 0.0% |
| | | b. | IOA for replacement behavior data. | 0.00 | 0.0% |
| | | c. | IOA meets minimum expectations. | 0.00 | 0.0% |
| | 2 | PBSP data are graphed at least monthly | | 1.80 | 90.0% |
| | 3 | Data graphs are adequate for interpretation (All items below must be FS for this to be scored FS). | | 0.90 | 0.0% |

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psychiatric treatment, and use and impact of psychotropic medications.

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| | a. | The graph is appropriate to the nature of the data. | 1.80 | 90.0% |
| | b. | Horizontal axis and label. | 2.00 | 100.0% |
| | c. | Vertical axis and label. | 2.00 | 100.0% |
| | d. | Condition change lines. | 0.20 | 0.0% |
| | e. | Condition labels. | 0.20 | 0.0% |
| | f. | Data points and path. | 2.00 | 100.0% |
| | g. | IOA and data integrity. | 0.20 | 0.0% |
| | h. | Demarcation of changes in medication, health status or other relevant events. | 0.20 | 0.0% |

The Behavior Services department at DSSLC uses spreadsheet software to compile treatment data and generate data graphs and progress notes. There are various strengths and weaknesses of this approach, all of which are described in Section K4.

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.

The table below presents data on the ability of staff to implement and understand the PBSPs at DSSLC.

| | PBSPs can be understood and implemented by staff | Average Score | Percent FS |
|---|---|---|---|
| 1 | Staff are able to explain how they implement the individual's PBSP. | 0.70 | 0.0% |
| 2 | The facility implements a system to monitor and ensure treatment integrity. | 0.00 | 0.0% |
| 3 | Observations of staff and individuals demonstrate at least 80% treatment integrity. | 0.10 | 0.0% |
| 3 | Written style and length of plan allows for staff understanding. | 0.70 | 0.0% |

Observations of and interviews with direct support staff reflect that many staff have difficulties in understanding and/or implementing behavior interventions. In some cases, the difficulties relate to the technical or complex language used in the intervention plan. In other circumstances staff reported that the layout and organization of the plans made it difficult to read and implement them as intended. Other issues also inhibited implementation of PBSPs. Direct care staff frequently stated that low numbers of staff, the numerous responsibilities and the number of behavior problems made it extremely difficult to carry out PBSPs.

At the time of the site visit, DSSLC did not routinely assess the implementation of PBSPs. It is well understood that the application of any process will drift over time. Without ongoing training and assessment of intervention integrity, it will not be possible for DSSLC to ensure that PBSPs are being implemented as

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>intended and in a manner that is of benefit to the individual. A comprehensive system of treatment integrity checks and staff training must be implemented in order to meet the Settlement Agreement.</td><td></td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.</td><td>The table below presents data on the training of staff on the implementation of PBSPs.<br><br>In order to meet the conditions of the Settlement Agreement, DSSLC will need to ensure that all behavior interventions are implemented as intended. This includes ensuring that the resources are available and that staff members are trained to competence. Both issues require a multifaceted approach to training and assessment. The current method of training that involves reading the intervention and then submitting a written quiz will not be sufficient. Staff must be made familiar with the content of the intervention and should demonstrate they can apply the steps in the intervention plan. Training must take place at the onset of the intervention plan, but routine follow-up assessment and training must occur throughout the duration of the plan.<br><br>
<table>
<tr><th></th><th>Staff training on specific PBSPs</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td>Training logs reflect that all staff have received training on individual PBSPs':</td><td>1.80</td><td>80.0%</td></tr>
<tr><td></td><td>Overall purpose</td><td>1.60</td><td>60.0%</td></tr>
<tr><td></td><td>Specific objectives</td><td>1.60</td><td>60.0%</td></tr>
<tr><td>2</td><td>Staff training includes a combination of didactic, modeled and in vivo strategies.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>3</td><td>Staff training is conducted prior to PBSP implementation.</td><td>1.70</td><td>70.0%</td></tr>
<tr><td>4</td><td>Staff training is conducted throughout the duration of the PBSP.</td><td>0.00</td><td>0.0%</td></tr>
<tr><td>5</td><td>The facility has implemented a system to ensure that pulled and relief staff, receive competency based training on PBSPs they will be responsible to implement.</td><td>1.00</td><td>0.0%</td></tr>
<tr><td>6</td><td>Staff training is provided in part by the professional responsible for the development of the PBSP.</td><td>1.60</td><td>60.0%</td></tr>
</table>
</td><td></td></tr>
<tr><td>K13</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three</td><td>At the time of the site visit, DSSLC employed an abundance of psychology assistants and only four BCBAs. This easily allowed for an adequate ratio of psych assistants to BCBAs. At the same time, this condition fell far short of employing 1 BCBA for every 30 individuals. Due to the number of people living at DSSLC, it will be necessary to hire or train at least 18 additional BCBAs.</td><td></td></tr>
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| | 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. | | |

| | Ratio of psychology professionals and assistants to individuals | Average Score | Percent FS |
|---|---|---|---|
| 1 | Program maintains an average of 1 BCBA to every 30 individuals. | 0.00 | 0.0% |
| 2 | Program maintains one psychology assistant for every 2 BCBAs. | 2.00 | 100.0% |

**Recommendations:**

1. DSSLC needs to develop standards and procedures to identify when behavior services including PBSPs and other psychological services are appropriate, how they will be provided, what curricula or standard therapeutic procedures will be used, how fidelity of implementing those procedures by clinicians will be assessed, and how treatment effectiveness will be evaluated.
2. DSSLC should develop and implement a system to established parity between the psychologists with and without the BCBA in regard to skills in applied behavior analysis. If at all possible, all staff should obtain certification as a behavior analyst. It is also recommended that DSSLC establish a procedure to monitor progress in the acquisition of board certification as well as continuing education in applied behavior analysis. To supplement the BCBA training and ensure adequate skills in those psychologists not partaking of BCBA training, it will be essential that DSSLC develop and implement an internal training curriculum for the Behavior Services staff, as well as a process for monitoring the application of basic behavioral skills.
3. DSSLC should act to reduce the schism in the Psychology Department between the psychologists with and without board certification. Although achieving parity in skills will be helpful in this area, additional effort should be made to ensure that the Psychology Department is able to provide a coherent and consistent approach to the delivery of services.
4. DSSLC should consider expanding the external peer review process. External peer review should include more external participants, provide more frequent review and include a greater number of PBSPs.
5. DSSLC should conduct an audit of the resources needed to ensure adequate data collection. The facility should then develop a system to ensure that sufficient resources are allocated to the data collection process.
6. DSSLC should develop and implement a system for ensuring that staff possess and use the skills necessary for formal and informal behavior intervention. This includes developing competence in the basics of applied behavior analysis, as well as knowledge of and the ability to implement PBSPs correctly. It is recommended that training be competency-based and that staff assessment and training be conducted on an ongoing basis. Such competency-based training should be both foundational (that is, knowledge and skills of behavior intervention principles and practices) and specific to the PBSPs that staff will implement for individuals.
7. It is recommended that DSSLC establish standards for psychological assessments, as well as a system to monitor adherence to those standards. These standards should include parameters for how often standardized assessments should be conducted, as well as the structure and content of a psychological assessment.
8. DSSLC should ensure that assessment of behavior includes all factors potentially relating to the targeted behavior. Many of the reviewed records did not include a comprehensive assessment of mental illness, the behavioral correlates to mental illness symptoms and differentiating between

biological and environmental contributors to behavior displays.

| SECTION L: Medical Care | |
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| | **Steps Taken:**<br>**Documents reviewed:**<br><br>1. DSSLC Policy and Procedures Reviewed: See Section J.<br>2. Description of facility wide medical review system. including the audit tool developed by Dr. Punam Myer and the results of the most recent audit, and the risk audit tool used by physicians at HST meetings.<br>3. Most recent results of facility wide medical review system.<br>4. Review of medical quality improvement program description.<br>5. All policy and procedures (including nursing) related to seizure management<br>6. List of all individuals being treated for seizure disorders<br>7. Review of medical sections of records identified in section J<br>8. Review of seizure records (physician and nursing) of Individual #577, #522 #511, #297, and # 781.<br>9. Review of compete neurology clinic records for individual #412, #580, #221, # 170, and #286.<br>10. Review of unusual incidents investigation regarding incident of choking by individual #364, #505, #171, #372, and # 533.<br>11. Review of listing of individuals admitted to hospital with medical diagnoses.<br>12. Review of listing of individual seen in emergency room with medical diagnoses.<br>13. Review of medical staffing documents including budgeted position, and filled positions<br>14. Review of curriculum vitae and medical licensure of all staff physicians<br>15. On site review of three clinical and administrative death reviews<br>16. Assessment tools reviewed:<br>DSSLC Medical Risk Assessment Tool (revised 10-27-09)<br>DSSLC Health Status Meeting Risk Assessment (revised 10-15-09)<br>DSSLC Restraint debriefing form<br>DSSLV Emergency use of psychoactive medication checklist<br>DSSLV Medical Record Audit (06-09-09); submitted by Punam Myer MD<br>17. Reports reviewed;<br>DSSLC Drug Order Report –Anticonvulsants<br>DSSLC FY 10 Allegations Trending Report<br>Tracking of psychiatric diagnosis changes<br>QA Audit form for June, July, August, Sep 2009 – Dr Punam Myer<br>18. Review of the requirements of the Health Care Guidelines (HCG)<br>19. Examination of recent administrative and clinical death reviews.<br><br>**People Interviewed:** Refer to section J.<br><br>**Meetings Attended:** Refer to section J |

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| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor Assessment:**<br><br>Medical staffing at DSSLC was reviewed. DSSLC was budgeted for seven medical positions. The medical staff consisted of the Medical Director, five staff physicians and one nurse practitioner. Community based medical consultants provided a number of on-site clinics, including in the areas of neurology, ophthalmology, gynecology and scoliosis. An external consultant provided medical audits for quality assurance and quality improvement. Routine medical services were provided to the individuals who live at DSSLC in settings that were determined by clinical need. DSSLC had a 16 bed central infirmary which had capacity for overnight stays. Some of these beds were occupied by individuals who needed longer term sub-acute level of care, and other beds were utilized for individuals who returned to DSSLC after a hospital stay or emergency room visit. DSSLC also maintained two satellite clinics which were in located in proximity to individuals' living quarters. Medical rounds were conducted on a daily basis. To promote interdisciplinary communication, physicians led quarterly HST meetings. The medical staff met on a regular basis, and there was medical representation on many DSSLC oversight committees. There was an internal 24 hour physician on-call system. Off campus medical care was provided primarily via Denton Regional Medical Center (DRMC), and several area longer term care medical facilities. Communication with outside facilities was assisted by two RNs who served as full time hospital liaison nurses.<br><br>Records of selected individuals were reviewed, in order to assess both the level of medical care and the kinds of care provided at DSSLC. Information was reviewed regarding the care of individuals referred for emergency room care, for hospitalization, and regarding the care of individuals who experienced incidents which put them at risk, such as choking and aspiration. There was a particular focus on seizure management, which is reported in the heath care guideline section of this report. At the time of the monitoring team's tour of the facility, the census at the central infirmary was 16 individuals, and 26 individuals who normally live at DSSLC were hospitalized at area medical facilities.<br><br>The DSSLC medical review audit system was reviewed. It included inquiries about the organization of clinical charting in individual's records, and about the adequacy of display of allergies, illnesses and active medical problems. The medical audits reviewed whether treatments were consistent with diagnoses, whether there was proper use of consultants, whether the laboratory testing was complete and whether the overall medical care was appropriate. The audit also inquired about preventative care including immunizations, it reviewed external reports such as ER visits, and it reviewed the documentation of communication with family members, providers and others. The most recent application of the audit tool was reviewed. An additional level of medical review was accomplished during scheduled quarterly HST meetings. Physicians completed a monitoring tool which focused on areas of medical concern, and which was the basis for a determination of level of overall risk status.<br><br>The Medical Director and the Settlement Coordinator reviewed the DSSLC plan of improvement. Additionally, the Medical Director shared plans to monitor admitting medical diagnoses in comparison with discharge diagnoses for these same individuals. Comparison of these data will guide future analyses of |

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| | whether clinical signs and symptoms relevant to eventual final diagnosis were properly recognized, as the clinical circumstances developed. Separately, the Settlement Coordinator reviewed efforts being made at DSSLC to more efficiently tap medical data being collected in several departments. Such data will be used for quality improvement efforts including trend analyses |

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| L1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | The system in place at DSSLC for routine, preventative, and emergency medical care at DSSLC was reviewed. The Medical Department was budgeted for five physician II positions and two physician III positions. The Medical Department was under the direction of Dr. Steven Kubala, who had been at the facility for about two months. He was a hospitalist by background and training, and was employed at DSSLC as a physician III. Additional members of the medical department were Dr Dinesh Kagal (40 hours/week), Dr. Mary Lee (40 hours) Dr. Tai Kim (40 hours), Dr. Barbara Hankinson (40 hours), Dr. James Galbraith (30 hours), and Ms. Catherine Zemler, RNC NP-C (40 hours). Dr. Punam Myer was an external consultant who provided medical audits for quality assurance and quality improvement. DSSLC also employed a number of medical consultants, who provided on-site clinics in their area of specialty. Such on-site clinics included neurology, ophthalmology, gynecology and scoliosis. Nursing and administrative support for those clinics was provided. In some cases, specialty-specific longitudinal clinical records, which consisted largely of copies of consultation reports, were maintained in the clinic area. This provided the consultants with ready access to data needed to guide long term treatment decisions. Such historical data would otherwise have been difficult to access as the materials would have typically been thinned from the clinical records after one or two years. Without the specialty clinic files, such data could have been accessed only from hospital archives.<br><br>Routine medical services were provided to the individuals who live at DSSLC in settings that were determined by clinical need considerations including clinical acuity and complexity and needed level of care. As needed, individuals were seen at the "bedside" or other locations that were in proximity to their living quarters. DSSLC maintained two satellite clinics which were in some proximity to the living quarters. The two clinics were located on the two geographic sides of the campus, East and West. They were established and equipped to provide for routine clinic care. DSSLC also had a central infirmary which had capacity for overnight stays. It was centrally located in proximity to medical offices, the DSSLC pharmacy, and clinic space used for the specialty clinics. The DSSLC infirmary had 16 beds. Some of these beds were occupied by individuals who were in need of longer term sub-acute level of care. Other infirmary beds were utilized for individuals returning to DSSLC after a hospital or emergency room visit. The infirmary was near the Cedar Falls living area, the home for individuals who were more medically fragile. Dr. Kagal was the physician who had a primary assignment to the | |

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| | | infirmary and was also the medical attending for the Houston Park home area. At the time of the tour of the monitoring team at DSSLC, infirmary beds were reported to be fully utilized. DSSLC had an internal 24 hour physician on-call system, the utilization of which is further described below.<br><br>The monitoring team reviewed the manner in which DSSLC provided off campus medical care for individuals who required a higher level of care than can be provided on campus. The main medical facility utilized by DSSLC for both emergency room evaluations and general medical hospitalizations was the Denton Regional Medical Center (DRMC). The Medical Center was located only a few miles from DSSLC and could be easily accessed within minutes. After completing care at DRMC, some individuals required additional medical care, before they were ready to return to DSSLC. Such individuals were referred to one of several longer term care medical facilities in the Greater Denton area. DSSLC has long maintained close ties with DRMC. The Medical Director stated that he was working to strengthen those ties, by developing a more formal relationship with a designated hospitalist at DRMC. Such an arrangement with an outside physician who is both familiar with both DSSLC and its medical staff has the capacity to enhance integration and quality of treatment. DSSLC supported the quality of care of individuals referred to DRMC via the utilization of two RNs who serve as full time hospital liaison nurses. At the time of the of the monitoring team's tour of the facility, 26 individuals who normally live at DSSLC were hospitalized at area medical facilities. At the next visit, the monitoring team will do an in-depth review of the use of area medical facilities.<br><br>The Medical Director described the work rounds and meetings attended by the medical staff. There was a medical meeting every day at 8AM in the infirmary in which relevant acute care issues were reviewed. These issues include individual by individual reviews of the medical status of individuals who were in the hospital, and also matters that took place over the prior 24 hours, including the off-hours covered by on-call physicians. This monitor attended the medical AM medical meeting on 03-30-10. About 20 physicians and nurses participated in the meeting, including the infirmary staff, the Medical Director and many of the DLLSC physicians, the CNE and the hospital liaison RN's. The meeting was medically substantive, it was run in orderly and efficient manner, and the materials discussed were highly pertinent and focused on transfer of the most relevant information needed for continuity of care.<br><br>The Medical Director reviewed the manner in which staff physicians provided direct care through planned and as-needed medical examinations. To promote integration of care, physician led quarterly Health Status Team (HST) meetings in which core staff from medicine, nursing, psychiatry, pharmacy, allied medical fields, QMRP and other provided timely updates of medical, safety and risk issues. These matters were then integrated into the quarterly review of the PSP. Some 7-10 individual were reviewed in each HST. | |

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| | | This monitor attended one such meeting with Drs. Lee and Satpathy. The meeting was necessarily fast moving but substantive. Changes in health status were reviewed and considered by the physicians with input from the care manager and pharmacist.<br><br>Documents and records were reviewed with a focus on both the care of individuals, and the kinds of care provided. DSSLC provided information on cases of individuals referred for emergency room care, for hospitalization, on the care of individuals who experienced incidents such as choking and aspiration, which put them at risk.<br><br>Medical record reviews of individual who received care from the epilepsy clinic were reviewed. For details see HCG section, below. | |
| L2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement. | The DSSLC medical review system was developed by Punam Myer, MD., MPH, CHCQM. It consisted of 28 items and included inquiries about the organization of charting and the adequacy of display of allergies, illnesses and active medical problems, The review asked whether treatment(s) were consistent with diagnoses, whether there was proper use of consultants, whether laboratory testing was complete, and whether overall medical care was appropriate The review also explored preventative care including immunizations, it explored whether external reports such as ER visits were documented in the record, and it explored whether there was documentation of communication with family members providers and others. The most recent application of the audit tool was reviewed. Dr. Myer was unable to be at DCCLC during the monitors visit, and the monitoring team was not able to meet with her to discuss specifics regarding the application of the review tool. This will be done during the first compliance review. An additional level of medical review was accomplished during scheduled quarterly HST meetings. Physicians were provided with a monitoring tool based on risk factors. The tool was completed during these meetings and it served as the basis for identification of individuals who were at greater level of medical risk. This monitor participated in such a review. The discussion was focused and relevant. Changes in the risk levels assessment were undertaken at the meeting and action steps were identified which could reduce risk, For example there was discussion about a possible reduction in polypharmacy , to reduce risk.<br><br>Clinical and Administrative Death Reviews were examined, to assess the quality assurance aspects of the peer review process. The proceedings followed the process outlined in the DADS policy directives 09-001 and 09-002. | |
| 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 | This monitor met with both the Medical Director and the Settlement Coordinator to discuss medical quality improvement. The facility plan of improvement provided guidance to plans for quality improvement. In addition to those planned but not yet implemented, a number of steps were either planned or were already in steps of partial implementation. The Medical Director shared plans to examine the records of | |

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| | 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. | individuals admitted to hospitals, and to compare the admission and discharge diagnoses. These data will guide retrospective analysis of whether clinical signs and symptoms relevant to what later emerged as the final diagnosis were properly obtained as the clinical circumstances developed. The Settlement Coordinator also reviewed efforts being made at DSSLC to more efficiently tap medical data already collected by several departments, for purposes of quality improvement reviews such as the facility TAC. Examples of such data included data collected by nurse care managers on diabetes, weight, and other metabolic parameters, data collected by hospital liaison nurses, by infection control and skin integrity nurses, and by HST meetings. DSSLC was fortunate to have a data analyst. This monitor was informed that over the coming months mechanisms for tapping medical information for use by medical quality improvement committee will be more fully developed. A description of the planned analysis and activities will be provided to the monitors, hopefully at the next tour of the monitoring team. | |
| L4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | Folders of the current DSSLC policies and procedures were made available to the monitors. Many of the procedures were newly revised and reflect improvement and enhancements of early procedures. The DSSLC policy and procedure for death reviews and the relevant DADS guidelines were reviewed. | |

**Recommendations:**

1. HCG guidelines for seizure management should be reviewed. For example, per item C.1S the neurologist should document the rationale for continued anticonvulsant treatment for individuals who have not had a seizure for five years.
2. Continue efforts to enhance capture of relevant medical information already collected at DSSLC, for purposes of medical quality assurance and quality improvement.
3. Continue emphasis on collaboration between neurology and psychiatry, for individuals supported by both services.

| **SECTION M: Nursing Care** | |
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| Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Campus Map<br>2. DSSLC Administrative Organization Charts<br>3. DSSLC Record Order and Purging Schedule for Residential Medical and Program Records<br>4. DSSLC Client Roster by Home<br>5. DSSLC Job Code Title List<br>6. DSSLC Plan of Improvement Tracking Log<br>7. DSSLC Home Shift Log for Direct Care Staff Instructions from Nursing, Houston Park, 03/01/10 through 03/26/10 for individuals # 588, #769, #33, #111, #733, #514, #371, #341, #285, #3, #510, #658, #243, #224, #359, #699, #361, #359, #361, #95, #75, #539, #568, #394, #97, #394, #381, #352, and #752 (obtained onsite)<br>8. DSSLC Hospital Liaison Worksheets, March, 2010, for individuals #248, #37, #769, #621, #662, #643, #50, #72, #240, #690, #409, #533, #507, #496, #664, #353, #129, #55, #107, #329, #326, #499, #245, #214, #252, #758, #602, #549, and #589<br>9. DSSLC Orientation/Pre-service Training Schedule, March, 2010<br>10. DSSLC Physical Management Training Curriculum<br>11. DSSLC Weekly Nursing Report (Total Number of Active and Budget Positions( FTEs) and Number of Current Vacancies (FTEs), 09/7/09 through 02/15/10<br>12. DSSLC Contract FTE Position Monthly Reporting For, 09/09 through 01/10<br>13. DSSLC Nursing Supervisor Shift Reports, including Staffing Assignments (coverage) by shift, 09/09 through 02/10<br>14. DSSLC Nursing Policies and Procedures:<br>• Acute Illnesses and Injuries, Reviewed/Revision Date: July 2009<br>• Bowel Management Policy<br>• Weight, Intakes and Output and Bowel Patterns, Effective February 27, 2009<br>• Infirmary Nursing Care<br>• Drug/Drug and Food/Drug Interactions, Effective March 3, 2009<br>• First Dose of Medications, Effective, March 3, 2009<br>• Fracture Protocol, Reviewed/Revision Date: July 2009<br>• Guidelines for Nursing Assessments, (Rev 01/12/10)<br>• Intake and Output, Reviewed/Revision Date: July 2009<br>• Nursing Documentation 0 Acute Care Plans<br>• Standing Order Protocol<br>• Weight Monitoring Procedure, Reviewed/Revision Date: July 2009<br>• Competencies, Reviewed/Revision Date: July 2009<br>• Aspiration Pneumonia Clinical Protocol, House-Wide Clinical Protocol, Reviewed/Revision Date: October 2009<br>• Immediate Care for a Seizing Resident, January 12, 2009 |

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| | • Seizure Management<br>15. DSSLC QA Review of Chart Monitoring Tool for Nursing (blank tool), Rev. 03/25/10 (obtained onsite)<br>16. DSSLC QA Nursing Care Assessment Monitoring Reports, July, 09 through November, 2009<br>17. DSSLC QA Chart Review Monitoring for Nursing Reports, March, 2010<br>18. DSSLC QA Nursing Care Assessment Monitoring Report Summary, May, 09 through March, 2010<br>19. DSSLC QA Medication Pass Observation List (schedule), February and March, 2010<br>20. DSSLC QA Medication Administration Observation M6.1 Reports, January, February and March, 2010<br>21. DSSLC Policy: Psychological Services CMGMT-24. Date: 2/19/10<br>22. DSSLC Psych-Med Clinic minutes, 03/29/10<br>23. Texas Department of Aging and Disability Services, Office of Management Support and Oversight of State Schools, Administrative Death Review, Policy Directive 09-002<br>24. Department of Health and Human Services Center for Medicare and Medicaid Services Survey, 12/03/09<br>25. DSSLC Responding to Hazards and Emergencies Training Curriculum, 12/15/09<br>26. DSSLC Fire Drill or Orientation Training Curriculum, 04/16/09<br>27. DSSLC Department of Aging and Disability Texas (DADTX) Course Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) certification, printed 02/22/10<br>28. DSSLC QA Nurse Emergency Equipment Monitoring for 502C, 502D, 512B, 512D, 512C, and 512A, dated 03/10/10<br>29. DSSLC Emergency Equipment Monitoring Check Sheets, 03/10/10 (obtained onsite)<br>30. DSSLC Control Drug Sheet and Equipment Checklist for 512A and 513B, 03/24/10 through 03/28/10<br>31. DSSLC Security Equipment Verification Checklist , 07/01/09 through 03/25/10<br>32. DSSLC Mock Medical Drill Check Sheets, 07/2/09 through 01/21/10<br>33. DSSLC Appointments Table, printed for February 19, 2010and March 30, 2010<br>34. DSSLC Medication Administration Policy, Reviewed/Revision Date: February, 2010<br>35. DSSLC Pharmacy and Therapeutic Committee, Policy and Procedure, February 1, 2010<br>36. DSSLC Pharmacy and Therapeutic Committee Minutes, 07/29/09, 10/29/09, 01/12/1-, and 02/17/10<br>37. DSSLC Medication Administration Committee Minutes, 06/26/09 through 03/26/10<br>38. DSSLC Medication Error Committee Policy, Date: 03/09<br>39. DSSLC Medication Error Reports with Corrective Action Taken, 07/06/09 through 02/25/10<br>40. DSSLC Sample MARs for individuals #337 and #267<br>41. DSSLC Infection Control Manual<br>42. DSSLC Infection Control Teaching and Information Sheet for Various Infections:<br>• Standard Precautions and Handwashing, including Signed Training Records<br>• Center for Communicable Disease (CDC), Campaign to Prevent Antimicrobial Resistance in Healthcare Settings, December 5, 2003<br>• CDC, Laboratory Detection of Oxacillin/Methicillin-resistant Staphylococcus areus, February 2, 2005<br>• CDC, Vancomycin-resistant Enterococci (VRE) and the Clinical Laboratory, December 5, 1999<br>• CDC, Influenza Vaccine, 2009 H1N1, October 2, 2009<br>• CDC Hepatitis B Vaccine, July 18, 2007 |

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| | • CDC, Inactivated Influenza Vaccine 2009-10, August 11, 2009<br>• Texas Department of State Health Services, HIV/AIDS and the Workplace, 10/2007<br>• CDC, Haemophilus Influenzae Type b (Hib) Vaccine, December 16, 1998<br>• Texas Department of State Health Services, Hepatitis B, Treatment, Signs and Symptoms, and Prevention<br>• Boils/Skin Abscesses Information Sheet<br>• Chickenpox Information Sheet<br>• Lice (Head/Body) Information Sheet<br>• Clostridium difficile Information Sheet<br>• Herpes Simplex Information Sheet<br>• Human Bites Information Sheet<br>• Molluscum contagiosum' Information Sheet<br>• Mononucleosis Information Sheet<br>• Multi-Drug Resistant Organisms Information Sheet<br>• Mumps Information Sheet<br>• Pinworms Information Sheet<br>• Pneumonia Information Sheet<br>• Respiratory infections Information Sheet<br>• Ringworm Information Sheet<br>• Salmonellosis Information Sheet<br>• Scabies Information Sheet<br>• Shingles Information Sheet<br>• Fact Sheet on Strongyloidiasis<br>• Urinary Tract Infections Information Sheet<br>43. DSSLC Individual with Pneumonia, printed 03/30/10 (obtained onsite)<br>44. DSSLC Pneumonia Tracking Sheet, printed 03/30/10 (obtained onsite)<br>45. DSSLC List of Persons with Skin Breakdown, March 30, 2010 (obtained onsite)<br>46. DSSLC Infection Control Committee Quarterly Reports, October 2009 and January 2010DSSLC Sample Client Immunization Report, 502C Cedar Falls - Infirmary, printed 03/29/10<br>47. DSSLC Monitoring Tool for Handwashing Reports, July through December, 2009<br>48. DSSLC Communicable Diseases – Cedar Falls (example), 03/12/10- through 03/29/10<br>49. DSSLC Drug Utilization Report – Antibiotics, 03/12/10 to 03/14/10<br>50. DSSLC Communicable Diseases by Select Code, 06/01/09 through09/30/10<br>51. DSSLC Positive PPD and CXR List, (obtained onsite)<br>52. DSSLC Nurse Manager Key Clinical Attributes Monitoring to for individual #409, 03/28/10<br>53. DSSLC Nurse Manager Key Clinical Attributes Monitoring to for individual #534, 03/10/10<br>54. DSSLC Hospitalization Reports by Hospital Liaison for individuals ##248, #37, #769, #621, #621, #662, #643, #50, #72, #240, #690, #409, #533, #507, #496, #664, #353, #129, #55, #107, #329, #326, #499, #245, #549, and #589<br>55. DSSLC Environmental Review Team Committee Minutes, 09/14/09, 11/09/09, 12/07/09, 01/15/10, 02/01/10, and 03/01/10 |

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| | 56. DSSLC Category A Medication/Treatment Error Form for individual #409, 03/28/10<br>57. DSSLC 24 Hours Nursing Report for Cedar Falls, 03/29/10<br>58. Records Reviewed: #s 138, 568, 409, 335, 419, 496, and 569<br><br>**People Interviewed:**<br>1. John Beall, RN, MSN, DNP, Chief Nurse Executive<br>2. Sherry Courtney, RN, Nursing Operations Nurse<br>3. Sharon Lancaster, RN, Hospital Liaison Nurse<br>4. Christie Sewell, RN, Diabetes Educator<br>5. Jacqui Garrison, RN, Nurse<br>6. Dawn Jones, RN, Nurse Manager, Timberhill Unit<br>7. Donna Gidcumb, RN, Hospital Liaison Nurse<br>8. Sibylle Graviett, RN, Case Manager Supervisor<br>9. Johnna Hayes, RN, Wound Care Nurse and House Supervisor<br>10. Susan Hyde, RN, Nurse Manager, Cedar Falls Unit<br>11. Robert Carpus, RN, Nurse Manager, Infirmary<br>12. Tonya Winget, RN, Nurse Manager (in training), Westridge and Garden Ridge Units<br>13. Sherrie Jones, RN, Nurse Manager, Houston Park Unit<br>14. Rebecca Wilkins, Quality Assurance Director<br>15. Laura Stoffels, RN, BSN, Quality Assurance Nurse<br>16. Carolyn Boggess, RN, BSN, Quality Assurance Nurse<br>17. L Barnett, RN, Nurse Educator<br>18. John Miuru, RN, Case Manager, Westridge Unit<br><br>**Meeting Attended/Observations:**<br>1. Tour of Cedar Falls, Houston Park, and Infirmary – informal interviews with nursing staff, QMRP, 512 physician, and security officer. 03/29/10<br>2. Mock Emergency Medical Drill, Houston Park, 515, 03/30/10<br>3. Medication Administration Enteral Nourishment Observations, 515B, 03/29/10<br>4. Infirmary Morning Rounds, 03/30/10<br>5. Infirmary Nursing Shift Report, Shifts 6-2 to 2-10, 03/31/10<br>6. PSP Meeting for #419 and #138<br>7. Chief Nurse Executive and Nursing Leadership Meeting, 03/30/10<br>8. Rebecca Wilkins, QA Director and QA Nurses, 03/30/10<br>9. HST Meeting, 504B, 03/30/10<br>10. RN Case Manager Meeting, 03/30/10 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>DSSLC's Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing data at the time of the reviewed indicated the following information for Full Time Equivalence (FTEs) filled and unfilled positions: 14 Nurse IV, three unfilled, 69 Nurse III, 23 unfilled, 56 Nurse II, 27.50 unfilled, and 84.10 LVN II, 13.90 unfilled. Unfilled nursing positions were filled by the use of three nursing agencies. The Chief Nurse |

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| | Executive reported that the facility was able to meet the minimum staffing ratios by using nursing agencies to supplement the unfilled nursing positions. Nursing structure consisted of a Chief Nurse Executive (CNE), Nursing Operation Officer, Infection Control/Employee Nurse, Wound Care Nurse, two Hospital Liaison Nurses, Diabetic Nurse Educator, Nurse Educator, Nurse Managers, Nurse Case Manager Supervisor, Case Management Nurses, Shift Supervisors, House Supervisors, Clinic Nurses, and Staff Nurses (RNs and LVNs).<br><br>DSSLC's QA Department had two full time QA nurses. One QA Nurse observes quarterly medication administration passes for all nurses who routinely passed medications. The information was compiled into a spreadsheet and shared with the CNE, nurse managers, and the nurse educator. Retraining was completed on the spot when needed and information shared. If there were any significant issues the nurse was observed a second time. In addition to medication observations this QA Nurse also completed chart reviews. The results were placed into the QA Monitoring folder online for PIC members to review as well as discussed in the monthly PIC meetings. Any significant issues identified were shared with the CNE, Unit Directors, and Nurse managers at the time of the observations.<br><br>The Nursing department had developed a few monitoring tools and were in the process of developing additional tools. An internal Peer Review System would serve to improve quality of services and enhance skills and practices of nurses. The nursing management staff did not have a clear understanding of the SA and HCG requirements, although they were working on their section of the Plan of Improvement (POI). Copies of the draft SA and HCG Monitoring Tools were given to the CNE. Cross-walking the draft SA Monitoring Tools with the SA and HCG would help the nursing staff better understand the expectations for compliance and would be helpful in revising and/or developing their own audit tools. Regular peer reviews need to focus on the identification of strengths and weaknesses of nursing practices, with analyses of nursing practices, and identification of problematic trends with plans of correction directed toward problems identified.<br><br>Review of Annual and Quarterly Nursing Assessments and accompanying Health Maintenance Plans and Acute Care Plans as well as integrated progress notes validated the use of North American Nursing Diagnoses Association (NANDA) nursing diagnoses for health issues identified requiring nursing interventions.<br><br>Review of records demonstrated that Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar. Sections listing lab values and diagnostic tests, consults, and system reviews usually provided comprehensive and detailed information regarding results of labs, diagnostics , consults, hospitalizations and emergency room visits, medications, treatments, and almost always contained substantive information documented in their respective comment sections and nursing summaries describing clinical outcomes. The nursing case managers need to continue to strengthen comment sections and summaries to include whether individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and recommend to other disciplines changes in strategies, supports, and/or services when indicated.<br><br>Noticeably missing in the Annual and Quarterly Nursing Assessments and HMPs were Self Administration |

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| | of Medication (SAM) Program assessments and plans. According to facility policy nursing was responsible for implementing SAM programs and collecting data. Review of the Annual and Quarterly Nursing Assessment form indicated there was no printed space for this information. SAM data sheets in the MARs reviewed were not consistently completed with each medication pass as required by facility policy and procedures. The Nursing Department needs to ensure that nurses follow the SAM policy and procedure for completing individuals' SAM program with documentation of data at each medication pass.<br><br>DSSLC's Nursing department has recently developed and implemented numerous nursing policies, procedures and protocols, as listed in the above documents. They were thoroughly reviewed and found to be in alignment with the current acceptable professional standards of nursing practice defined in the Settlement Agreement (SA) and Health Care Guidelines (HCG). The Lippincott Manual of Nursing Practice, fourth edition and Mosby's Clinical Nursing were used as references. As these policies, procedures, and protocols mature and are followed it is expected that nursing care will continue to demonstrate improvement.<br><br>DSSLC was using the Health Risk Assessment Tool-Nursing Section as the tool for the identification of clinical risk indicators for individuals. The Health Risk Assessment procedure was of concern due to the fact there were no specific and/or clear criteria for determining risk levels<br><br>Review of the Communicable Diseases Reports indicated that infections data were reported by individual, unit, infectious disease, and antibiotic therapy through to resolution. This information is summarized into the Drug Utilization Report – Antibiotic Cumulative Report. The Infection Control Committee reviewed and discussed the information and took action when indicated. The facility did not have formalized system for analyzing and trending infection control data. The IC nurse reported that the quarterly Mortality and Morbidity Committee looks at trends using a Root Cause Analysis approach and takes corrective action as indicated. Medical Management Committee minutes were not available for review. There was evidence that staff were trained in standard precautions and handwashing techniques. The Infection Control Committee needs to develop and implement a formalized system to analyze and trend data to use as clinical indicators in managing infectious diseases.<br><br>Review of MARs identified numerous "holes" for some of the prescribed medications without circles or explanation as to why medications were not initialed. Accountability Sheets contained in each MAR use to assist in preventing medication error were not consistently completed. The Nursing department needs to develop and implement MAR monitoring procedures to track and trend data to improved medication administration practices, documentation, and prevent medication errors. The trend data needs to be included in Nursing Management Meetings, Medication Error, and Pharmacy and Therapeutic Committees. |

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| M1 | Commencing within six months of | DSSLC's Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing data at the | |

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| | 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. | time of the review indicated the following information for Full Time Equivalent (FTE) filled and unfilled positions: 14 Nurse IV, three unfilled, 69 Nurse III, 23 unfilled, 56 Nurse II, 27.50 unfilled, and 84.10 LVN II, 13.90 unfilled. Unfilled nursing positions were filled by the use of three nursing agencies. . The Chief Nurse Executive reported that the facility was able to meet the minimum staffing ratios by using nursing agencies to supplement the unfilled nursing positions. Full time nursing positions were difficult to fill due to the competitive Dallas market, coupled with the state's salary compensation as compared to the private sector.<br><br>DSSLC's Nursing structure consisted of a Chief Nurse Executive, Nursing Operation Officer, Infection Control/Employee Nurse, Wound Care Nurse, two Hospital Liaison Nurses, Diabetic Nurse Educator, Nurse Educator, Nurse Managers, Nurse Case Manager Supervisor, Case Management Nurses, Shift Supervisors, House Supervisors, Clinic Nurses, and Staff Nurses (RNs and LVNs).<br><br>DSSLC's Nursing department provides 24/7 nursing care to 558 individuals who reside in seven residential units, a central infirmary with two satellite clinics and five onsite clinics. Nursing services use a case management approach to deliver services. Case load assignments for case managers and staff nurses were based on acuity levels. Review of the Nursing Supervisor Shift Reports and Staff Assignments from 09/10 through 02/10, demonstrated that a shift count for coverage was made daily for each shift, and each residential unit, therefore, ensuring adequate nursing staffing was available.<br><br>All nurses, including agency nurses receive two weeks orientation in the class room with didactic instruction by the nurse educator. After the orientation nurses were assigned to their respective units with a preceptor who follows new nurses for 10 days or until the preceptor and/or new nurse felt ready to function independently. The Nursing department provided continuing education on topics relevant to high risks and topics unique to individuals with intellectual and developmental disabilities. Annually the nurse educator and nurse managers conduct a Health Fair for training and skills assessment. The Columbus Organization also provides periodic specialized training to the nursing staff. Other training was provided by other professionals and non-professionals on special topics of interest. The CNE reported that he is in the process of arranging for Continuing Education Units (CEUs) for the nurses through the Texas Nursing Association.<br><br>Review of nursing training material included Physical Management. Nurses do not routinely participate in mealtime observation. The nurse case managers performed dining monitoring observations quarterly on a 5% sample. If an individual experiences difficulties while dining, it is the DCPs' responsibility to determine whether or not the severity of the individual's difficulty rises to the level necessary for assessment by a | |

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| | | nurse. It is of concern that the DCP staff may not readily recognize subtle signs and symptoms of aspiration and refer to the nurse for assessment. Because of the high risk for choking and aspiration, leading to aspiration pneumonia in this population, nursing needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by the nurses.<br><br>Review of the Home Shift Logs for Direct Care Staff - Instructions from Nursing, and Infection Control Information Training Sheets, demonstrated enhanced systems for communicating and training DCP staff on individual specific instructions to be carried out relating to acute illness/Injuries and infections control issues. The nursing staff needs to ensure that instructions communicated to DCPs on the Home Shift logs are documented in the integrated progress notes.<br><br>Observation of the Infirmary Morning Rounds and Nursing 6-to 2-10 Shift Report and review of the 24 Hour nursing Log demonstrated a detailed report on each individual's health care status, any assessment, changes in Physician's Orders and/or nursing care plans (acute and/or chronic), and follow-up care instructions for oncoming nurse.<br><br>Interview and review of the Hospitalization Reports prepared by the Hospital Liaison Nurses, for the hospitalized individuals listed in the above documents, provided comprehensive nursing assessments detailing the individuals health status, diagnostic and laboratory results, treatments, medications and general care received, their therapeutic response to treatment, and plans for discharge. The Hospital Liaison Nurses identified follow-up care and training needs and communicated to the appropriate discipline. All reports were scanned into the facility's computer shared drive, in each individual's record, for all relevant PST members to review and act upon as indicated. In addition to placing the hospitalization documentation in the shared drive, Hospital Liaison Nurses need to place hard copies chronologically in the integrated progress notes to ensure continuity of care.<br><br>The Quality Assurance (QA) Director discussed the QA process for nursing from the QA Department. One full time QA Nurse III observes quarterly medication administration passes for all nurses who routinely passed medications. The information was compiled into a spreadsheet and shared with the CNE, nurse managers, and the nurse educator. Retraining was completed on the spot when needed and information shared. If there were any significant issues the nurse was observed a second time. In addition to medication observations this QA Nurse III also completed chart reviews. The results were placed into the QA Monitoring folder online for Professional Improvement Committee (PIC) members to review and discuss at the monthly PIC meetings.<br><br>One full time QA Nurse IV completed Chart Monitoring Tools and entered them into a | |

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| | | spread sheet. This information was shared with the CNE, Nurse Managers, QA Director, Unit Directors, Director of Residential Services, Director of Program Coordination, and PIC members. The results were placed into the QA Monitoring folder online for PIC members to review as well as discussed in the monthly PIC meetings. Any significant issues identified were shared with the CNE, Unit Directors, and Nurse managers at the time of the observations. In addition, the QA Nurse IV serves on numerous committees: monthly Med Error Committee, quarterly Infection Control Committee, monthly Pharmacy and Therapeutic Committee, and Clinical Death Reviews. There was also a form completed for every death, (i.e., Quality Assurance of Nursing Services Death Reviews). This information was provided to the Settlement Agreement Coordinator (SAC) who requested corrective action plans when needed. Recommendation for corrective action was not available for review.<br><br>Review of the Chart Monitoring Tools for March, 2010, completed by the QA Nurses indicated items were monitored related to SA Sections: G, H, I, J, L, M, and N. This was a newly implemented tool. Seven different monitoring tools were completed. Approximately three records were reviewed in each of the sets with an overall percentage of "yes" indicators scored for each item on each set of tools and then a percentage summary was given for the overall review. The Chart Monitoring Tools also included an overall summary of percentage of "yes" indicators for combined reviews. The questions on the tool were designed to answer "yes" or "no". The questions focused on whether items were present and failed to address the quality of the information. Some of the questions asked were "double barreled" where part of the question could be answered "yes" and the other part "no", therefore nullifying the answer. Such questions should be avoided and two or more separate questions asked instead to provide for an accurate response. Listed in the chart below are percentage of items falling below 100% by item and the overall percentage for all items reviewed:<br><br>**Chart Review Monitoring** — **Mar-10**<br>Item — % of Yes<br>H2.1 — Does all medical staff including psychiatrist use current ICD and DSM codes for diagnoses? — 0%<br>H4.1 — Are there health related care plans (medical care plan and chronic nursing care plan as evidenced by the nursing problem list on the medical chart)? Does the problem list match the health management plan for this individual? — 95%<br>G1.4, L1.7, Q1.2, Q2.3 — Do integrated progress notes (IPN) show communication between disciplines (medical provider, psychology, psychiatry, nursing, dentistry, pharmacy, PT, ST, dietary, and OT)? — 90%<br>M1.1 — Are focused nursing assessments, follow-up and resolution of any acute injury or illness documented in the IPN? — 86%<br>M4.6 — Did the nurse complete a thorough focused assessment for acute health issues utilizing the SOAP format prior to contacting the provider when feasible as | |

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| | | | evidenced by the IPN and physician orders on the individual's record? | | |
| | | L1.6 | Are weights, vital signs and oxygen saturation percentages monitored monthly as evidenced by a flow sheet from nursing and direct care staff? | 17% | |
| | | L5.3 | Is there evidence that significant weight changes were monitored monthly and that medical provider and case manager met to discuss interventions? | 92% | |
| | | M6.3 | Is Medication Administration Record (MAR) complete with no omissions of signatures and signed according to Initialing Accountability MAR? | 21% | |
| | | M6.3 | Are any errors or omissions submitted on a medication error form to include extra dose, wrong administration technique, wrong patient, wrong time, wrong dosage, wrong route or wrong drug and is this reported to nursing and pharmacy? | 17% | |
| | | M6.8 | If participation in a SAM's program was approved by the PST or HST was a formal program put in place as evidenced by a form in the MAR? | 67% | |
| | | M6.8 | Is there proof in the individual's MAR that the SAM program was followed by the medication nurse consistently? | 50% | |
| | | G1.3 H5.1 I1.4 L1.3 M3.1 M4.5 M5.2 | Did the health status team meet at least every 6 months to discuss the individual and include but not limited to: aspiration, choking, behavior, injury, cardiac, constipation, dehydration, diabetes, TI, hypothermia, osteoporosis, respiratory, seizures, skin integrity, UTIs, weight, and polypharmacy? | 93% | |
| | | I2.1 | Is there a PSP addendum within 5 working days to address problems from an individual rated as medium or high risk on the risk levels from HST? | 36% | |
| | | I3.1 | Is there a plan implemented within 14 days for any individual rated as high risk on the risk evaluation at the HST? | 76% | |
| | | M5.3 | Did the nursing care manager convene the personal support team to discuss immediate and additional interventions for significant weight loss/gain as evidenced by the PSP quarterly meeting or PSP addendum? | 80% | |
| | | I1.6 | Does the PSP meet for individuals at high risk of falls to implement fall prevention plan? | 87% | |
| | | M4.7 | Does the 24 hour nursing report reflect that Standing Orders were implemented or whether there was an illness or injury to the individual? | 90% | |
| | | | Factoring in the items scoring 100% not included in the chart, facility's total score | 85.54% | |

The QA department needs to cross-walk the recently developed monitoring tools with the SA and HCG to ensure that all areas required for compliance are addressed. Items on the Chart Review Monitoring Tools that have "double barreled" questions need to be reviewed and revised into two or more questions to provide for an accurate response. The tools also need to address quality of care provided by clinical disciplines and make recommendations for corrective action. The QA department needs to analyze, track and trend clinical performance data to identify areas of practice and to ensure that non-compliant practices demonstrates improvements.

The Nursing department had developed a few monitoring tools and were in the process of developing additional tools. An internal Peer Review System would serve to improve

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| | | quality of services and enhance skills and practices of nurses. The nursing management staff did not have a clear understanding of the SA and HCG requirements, although they were working on their section of the Plan of Improvement (POI). Copies of the draft SA and HCG Monitoring Tools were given to the CNE. Cross-walking the draft SA Monitoring Tools with the SA and HCG would help the nursing staff better understand the expectations for compliance and would be helpful in revising and/or developing their own audit tools. Regular peer reviews need to focus on the identification of strengths and weaknesses of nursing practices, with analyses of nursing practices, and identification of problematic trends with plans of correction directed toward problems identified. The Nursing department needs to develop and implement an effective internal peer review process.<br><br>While touring Houston Park the CNE called a Mock Medical Emergency Drill in 515. The building nurses, security officer, respiratory therapist, campus coordinator and building coordinator responded in less than five minutes. The emergency equipment was checked and operational. The drill met accepted standards of professional practice except for the lack of participation by a physician. The emergency equipment was checked in Cedar Falls (512) and in the Infirmary. While the basic equipment to support CPR was present and operational, the equipment in Houston Park and Cedar Falls were not stored on an emergency cart for ready and rapid access for transport. The facility's Unit emergency equipment needs to be placed on an emergency cart for ready and rapid transport.<br><br>The Infirmary had a fully stocked and operational emergency cart capable of supporting Advance Cardiac Life Support (ACLS). The CNE reported in the event of a real "code" the Infirmary emergency cart would be brought to the scene. This emergency cart can be transported to the scene in the Infirmary within five minutes. In addition, the emergency equipment contained in the security vehicle was inspected and found to be complete and operational. Because it was unclear whether or how such emergency equipment would be brought to an emergency in another building, this will be reviewed at the first compliance visit.<br><br>Review of the Security Equipment Verification Sheet, 07/02/09 through 03/25/10, indicated that the emergency equipment was consistently checked on each shift. The Control Check Sheet and Equipment Checklist for 513B, 03/23/10 through 03/27/10 and 512A, 03/24/10 through 03/28/10, were completed daily on each shift except in 513B. In 513B, the sheet was not signed as checked by two nurses on the shifts 6-2 on 03/14/10 and 03/26/10. Review of the QA Nurse Emergency Equipment Monitoring 512B completed on 03/10/10, indicated the med cart Control Drug Sheet and Equipment Checklist was not filled out on 03/07/10 for shifts 2-10 and 10-6 and on 03/06/10 for shifts 6-2 and 2-10. The Nursing department needs to routinely monitor Control Check | |

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| | | Sheets and Equipment Checklists to ensure they are checked and signed by nurses every day and every shift.<br><br>Review of the Mock Emergency Drills completed 07/2/09 through 01/21/10 indicated that monthly drills were completed in all areas and on all shifts. The facility used the state's standardized Mock Emergency Medical Drill form. The facility failed to provide their local Emergency Medical Response Policy and Procedures. Therefore, it was not possible to validate whether the drill procedure were carried out according to policy. Only two of the many drills were marked "failed. " Only one of the two drills contained a plan of action for correction."<br><br>It was questionable how of all the many drills only two were marked "failed." Review of the Mock Emergency Medical Drill sheets, indicated that nurses only participated in two of the drills, respectively on 07/25/09 and 10/11/09. Physicians did not participate in the drills. The nurse who participated on the 07/25/09 drill checked that all related emergency equipment was present and working; however, the nurse who participated on the 10/11/09 failed to check that emergency equipment was present. The staffs participating in the other drills were primarily the DCP with few other ancillary staff. More often than not only one DCP was listed as having participated. In those drills the check boxes related to emergency equipment were marked "not applicable" (NA). It was of concern that the nursing and medical staff did not participate in the Mock Emergency Drills. The purpose for conducting Emergency Medical Drills was to ensure that all staff responsible for responding to medical emergencies maintained their skills, and drills test the facility's emergency preparedness.<br><br>According to the CNE, drills are reviewed by the Risk Management Committee.<br>The document request asked for committee minutes addressing code blue or emergency procedures but none were made available for review. Review and critique of Mock Emergency Drills was to ensure that staff were competent in responding to medical emergencies, all necessary emergency equipment were available and in working order, communication systems were working, and corrective action was taken when necessary.<br><br>Review of DSSLC Department of Aging and Disability Texas (DADTX) Course Due/Delinquent List for Cardiopulmonary Resuscitation (CPR) certification, printed 02/22/10, indicated that two health care personnel (campus nurse and dental hygienist) were delinquent as well as 91 ancillary personnel. Some personnel have not received basic CPR training since 2006.<br><br>Based on the above findings the facility fails to meet acceptable standards of professional practice for emergency preparedness. The facility needs to evaluate the Emergency Management Response system to ensure: | |

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| | | • Emergency Medical Response Policies and Procedures are in place and meet acceptable standards of professional practice.<br>• Physicians, nurses, and other ancillary personnel responsible for responding to medical emergencies participate in Mock Medical Drills<br>• All personnel required to maintain CPR certification are up-to-date in training.<br>• Mock Emergency Medical Drills are reviewed in the Risk Management Committee with minutes reflecting the discussion and any corrective action taken.<br>• The committee analyze, track and trend outcomes and recommendation for corrective action.<br>• QA department monitors all aspects of emergency management response. | |
| 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. | Review of records for individuals #138, 568, 409, 335, 419, 496, and 569 showed Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar. Sections listing lab values and diagnostic tests, consults, and system reviews provided comprehensive and detailed information regarding results of labs, diagnostics , consults, hospitalizations and emergency room visits, medications, treatments and almost always contained substantive information documented in their respective comment sections and nursing summaries describing clinical outcomes. The nursing case managers need to continue to strengthen comment section and summaries to include whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services. Annual and Quarterly Nursing Assessments enable the nurse to make comparisons of individuals' health status from quarter to quarter, culminating in a comprehensive annual assessment containing relevant information that contributes to developing health maintenance plans (HMPs) and provides the personal support team (PST) information from which to develop personal support plans (PSPs).<br><br>Noticeably missing in the Annual and Quarterly Nursing Assessments and HMPs were Self Administration of Medication (SAM) Program assessments and plans. According to facility policy, nursing was responsible for implementing SAM programs and collecting data. Review of the Annual and Quarterly Nursing Assessment form indicated there was no printed space for this information. The Nursing department needs to review their Annual and Quarterly Nursing Assessment Policy and Procedures and report forms to ensure the inclusion of SAM information.<br><br>HMPs were developed at the time of the Annual Nursing Assessment and PSP. New HMPs were developed when indicated throughout the PSP year. The HMP procedure and form does not require a signature validating that the nurse reviewed/revised the HMP quarterly. The Nursing department needs to include signature and date lines on the HMPs that ensures that they are reviewed and/or revised at the time Quarterly Nursing | |

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| | | Assessment are completed. | |
| M3 | Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised. | Review of individuals' #s 138, 568, 409, 335, 419, 496, and 569s' Annual and Quarterly Nursing Assessments and accompanying Health Maintenance Plans and Acute Care Plans as well as integrated progress notes validated the use of North American Nursing Diagnoses Association (NANDA) nursing diagnoses for health issues identified requiring nursing interventions. This was a positive finding because the use of NANDA, a standardized nursing language for documentation of care, is vital both to the nursing profession and the direct care nurse. The benefits to using this classification for nursing diagnoses include: better communication among nurses and other health care providers, increased visibility of nursing interventions, improved nursing care, enhanced data collection to evaluate nursing care outcomes, greater adherence to standards of care, and facilitated assessment of nursing competency.<br><br>Cross checking individuals' #s 138, 568, 409, 335, 419, 496, and 569 with their Nursing Annual and Quarterly Assessments and clinical indicators, e.g., Nursing Diagnoses, revealed the following information:<br>• Individual #409's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included the following Nursing Diagnoses with an accompanying HMP for each:<br>o Altered neurosensory function related to seizure activity;<br>o Altered elimination related to constipation;<br>o Risk for impaired skin integrity;<br>o Risk for injury related to history of falls and altered neurosensory status;<br>o Altered health maintenance related to routine screenings for health maintenance/wellness, GERD, Low extremity edema, osteoporosis, history of pneumonia, history of nephrolithiasis, and urinary tract infection; and<br>o Medical Care Plan addendum to Health Management Plan for all medical diagnoses.<br><br>During the review of individual #409's Annual and Quarterly Nursing Assessments for the past year, it was noted in each of Sections VII Physical Assessment – EENT Head and Neck, that "no otoscope was available on the unit." Therefore, the ear canals and tympanic membranes were not examined. Because of the potential for ear wax buildup and inflammatory processes, it was important to visualize the ear canals and tympanic membranes as part of routine assessments. A prudent nurse would have made reasonable effort to secure an otoscope and complete the exams. The Nursing department needs to ensure that | |

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| | | all units/nurses have otoscopes and other diagnostic equipment available and in good working order to complete physical assessments.<br><br>Review of individual #409's integrated progress notes, 09/29/09 through 02/14/10, indicated that all acute illnesses, injuries, seizure activity, hospitalizations, emergency room and infirmary visits, post sedation, and head injuries were appropriately assessed by nursing according to professional standards of practice and were monitored until problems were resolved. Individual #409's history and diagnoses include more than 20 diagnoses. Review of individual #409's Integrated Progress Notes, 09/29/09 through 02/14/10, Physician's Orders, 10/28/09 through 03/16/10, and Medical Care Plan Monthly Review Notes, 02/24/10, raised the following concerns:<br>o The Medical Care Plan Monthly, 02/24/10, reported a weight of 170.7 pounds, Average Weight Range (AWR) was 120 to 146. This represents 22 pounds or 17% above AWR. Individual #409 was prescribed a 1200 calorie, chopped, high fiber diet over the last year. Because of history of cardiovascular, gastro intestinal, and skeletal muscular system problems, being overweight had the potential to negatively impact these systems. The PST needs to further evaluate strategies to reduce weight to his AWR.<br>o Review of the above records indicated that Individual #409 had at least six reported episodes of vomiting, respectively on 10/8/09, 10/13/09, 10/30/09, 12/10/09, 01/16/10, and 01/31/10. During this time period Individual #409 had numerous complaints of chest and abdominal pain for which Individual #409 was seen in the Denton Regional Medical Center Emergency Room: On 10/25/09 Individual #409 was seen for complaints of chest pain and elevated blood pressure; cardiac enzymes, electrocardiogram, and laboratory values reported within normal limits. Individual #409 returned home and was monitored and treated symptomatically. On 11/16/09 Individual #409 was seen in the emergency room for complaints of abdominal pain. Computed Tomography Scan of abdomen was negative, laboratory values were within normal limits, except for low sodium. Individual #409 returned home and was monitored and treated. On 01/28/10 was seen, diagnosed and treated with antibiotics for a urinary tract infection. On 10/27/09 a renal sonogram revealed a non-obstructive 6 millimeter stone in left renal hilum. Individual #409 had a consult on 12/30/09 with an urologist who reported his urology condition as stable and recommended Individual #409 be watched for changes, ordered repeat kidney-ureter-bladder radiography again in one year, and Individual #409 be seen again. Individual #409 was seen again on 02/18/10 for | |

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| | | follow-up of nephrolithiasis and chronic kidney disease. In addition, over the past year his routine laboratory values for red blood (rbc)counts, hematocrit (hct), and hemoglobin (hgb) were reported to be low, with the 01/13/10 result respectively; rbc 4.5 (normal range 4.6-6.2), hct 35.2 (normal range 42-52), and hgb 11.4 (normal range 14-18). Reports of 01/09 and 07/09 hemocults were negative (report for ordered hemocults 04/09 and 10/09 not available for review).<br><br>On 02/12/10 an esophagogastroduodenoscopy and colonoscopy with biopsies were completed that revealed: Barrett's esophagus with mild gastritis, five colon polyps with biopsy, cecal polyps, tubular adenomas, transverse colon polyps biopsy. The results of the biopsy indicated invasive adenocarcinoma. On 03/01/10 Individual #409 had a consult with an oncologist. A colonectomy was performed on 03/22/10. Although individual #409 had a medical history of numerous acute and chronic conditions, it is plausible to wonder, based on age and risk indicators why more aggressive diagnostics, e.g., an EGD and colonoscopy with biopsies were not performed earlier to rule out colon cancer. Had these diagnostic been performed, it is possible the cancer could have been caught earlier before it advance to an invasive stage. DSSLC physicians and HST need to review #409's medical history to examine whether more could have been done to identify his colon cancer earlier.<br><br>• Individual #335's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included the following Nursing Diagnoses with an accompanying HMP for each:<br>o Alteration in neurosensory function related to seizure activity;<br>o Altered nutrition more than body requirement;<br>o Risk for impaired skin integrity related to history of superficial abrasions;<br>o Decreased cardiac output related to history of hypertension and uncompensated congestive heart failure;<br>o Altered health maintenance related to uncontrolled type II diabetes;<br>o Altered health maintenance related to osteoporosis;<br>o Altered health maintenance related to history of dystrophic toenails;<br>o Altered health maintenance related to altered renal status;<br>o Altered health maintenance related to major depressive disorder;<br>o Altered health maintenance related to maintenance of wellness; and<br>o Medical Care Plan addendum to Health Management Plan for all medical diagnoses. | |

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| | | Although individual #335 has a HMP and PSP relating to weight management, Individual #335 remains approximately 49 pounds over her AWR. This was a significant concern due to individual #335 diagnoses of type II diabetes and congestive heart failure and high risk for complication secondary to these diagnoses. Individual #335 is on a 1000 calorie-diabetic, chopped diet with increased fiber. There was evidence in her PSP in the OT/PT section regarding an exercise program to assist with weight loss but no specific plan or data. Her HST needs to consider additional strategies to promote weight loss.<br><br>Review of individual #335's Annual and Quarterly Assessments, Section XI Nursing Summary did not consistently document the effectiveness of HMPs.<br><br>• Individual #496's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included eight Nursing Diagnoses; each had an accompanying HMP.<br><br>While individual # 496's nursing diagnoses and HMP corresponds to identified health care needs, the Annual and Quarterly Nursing Assessments fail to provide substantive summaries in each of the systems portion of the plan or in the Nursing Summaries. The general quality of these assessments and findings were weak. The nurse manager/nurse case manager needs additional assistance in writing meaningful assessments and summaries of findings for individual #496.<br><br>• Individual #569's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included seven Nursing Diagnoses; each had an accompanying HMP.<br><br>• Individual #568's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included six Nursing Diagnoses; each had an accompanying HMP.<br>This Annual Nursing Assessment, summary and HMPs was exemplary; comprehensive and detailed in all aspects.<br><br>• Individual #419's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included seven Nursing Diagnoses; each had an accompanying HMP.<br>Individual # 419's AWR was 79-96 pounds. Individual #419's weight was reported at 170.4 pounds on the Quarterly Nursing Assessment, 01/04/10. | |

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| | | Individual #335 was over the AWR by 74.4 pounds. According to Individual #335's HMP and PSP Individual #335 was on a 1000, step two low cholesterol, ground texture, increased fiber diet with honey consistency fluids. Individual #335 also had an OT weight management plan. The PST and HST members need to review and re-evaluate individual #419's and individual #335's weight management plan to determine if there are additional strategies to assist with weight reduction.<br><br>Individual #419 sustained a fracture to the left fibula and tibia on 02/25/10 and was transferred to Denton regional Medical Center for treatment. She was discharged and admitted to the Infirmary on 03/01/10. Review of integrated progress notes reflected an appropriate nursing assessment at the time of injury/transfer to the hospital and upon her return. An appropriate Acute Care Plans for post fracture care and pneumonia were developed and implemented upon admission to the Infirmary. Individual #419 was diagnosed with a C-diff infection and treated with Flagyl 500 MG three times a day for seven days. Individual #419 was placed in isolation with standard precaution until Individual #419 finished the antibiotic therapy and had three negative stool cultures. An appropriate Acute Care Plan was implemented during the course of her infection. There was evidence in review of the Home Shift Log for Direct Care Staff that they were instructed of their responsibilities and that they carried out their responsibilities related to her Acute Care Plans.<br><br>• Individual #138's Annual Nursing Assessment Section XI Nursing Summary, Section X Health Management Plan, and Acute Care Plans included five Nursing Diagnoses; each had an accompanying HMP.<br>o Risk of impaired skin integrity related to history of minor skin irritations and injuries;<br>o Altered health maintenance related to history of cigarette abuse; and<br>o Risk of injury related to falls.<br>o Acute care Plan for:<br>▪ Bronchitis – initiated 02/16/10 and resolved 02/24/10<br>▪ Skin impairment related to pressure blister on 3rd left toe – initiated 03/17/10 resolved 03/30/10<br><br>During an individual's PSP meeting on 03/31/10, the monitoring team noted that his podiatrist refused to perform a bunionectomy to his left food because the bunionectomy performed on his right foot in 03/31/09 had not been properly managed and had not healed correctly. It was further reported that sometime after his surgery his toe splint had been lost. PST members did not know it had been lost. The CNE, case manager | |

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| | | supervisor and case manager was notified and thoroughly researched the issue in the record and conducted staff interviews for the lost splint. The CNE reported the following information:<br>• Surgery was performed on 03/31/09. Foot was still dressed. Seen by Dr. Sally, MD on 04/09/09 and dressing changed.<br>• Follow-up visit with Dr. Glauser on 05/01/09. Orders to wear night splint and toe spacer at all times. Follow-up visit in three weeks. Orders were transcribed on the MAR.<br>• Individual #138 was seen again on 05/22/09. Orders were to wear spacer during the day and night splint at night. Follow-up visit scheduled for six week. Orders transcribed on MAR.<br>• Spacer was present during both July and October Nursing Quarterly assessments. There was no documentation relating to the spacer was available from 10/05/10 through 12/29/09.<br>• On 12/29/10, during a follow-up appointment PT noticed that Individual #138 did not have a spacer. PT recommended discontinuing the night splint and spacer unless the doctor recommended it to be reinstated. The doctor did not reinstate the spacer. PT and HAB continued to follow him closely. PT also raised concern about Dr. Glauser scheduling the other foot surgery due to weight gain after the first surgery [caused by immobility from the first surgery].<br>• Individual #138 had recently developed blisters on the left foot. Nursing care was provided and the blisters were healed. Orders for this were on the MAR. Individual #138 was to be seen on 04/01/10 in the orthotics clinic.<br><br>During the course of researching the record for the lost splint, it was identified that nursing failed to develop and implement an Acute Care Plan post surgery that would have included care and monitoring for the use of the night splint and toe splint. Therefore, a report was sent to the Department of Family Protection Services (DFPS) for investigation of neglect.<br><br>Except for the failure to develop an Acute Care Plan for # 138, mentioned above, review of individuals #138, #568, #335, #419, #496, and #569's integrated progress notes (as noted earlier for individual #409) indicated that almost always acute illnesses, injuries, seizure activity, hospitalizations, emergency room and infirmary visits, post sedation, and head injuries were appropriately assessed by nursing according to professional standards of practice and were monitored through until problems were resolved. When antibiotic therapy was prescribed for infection, there was evidence that nursing assessed and documented therapeutic response at least on each shift. Although the notes did not specifically state "problem resolved," it was apparent through review of the notes that the acute problems were resolved. There was evidence that the physician was notified of | |

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| | | acute illnesses and injuries. Nearly all notes were written in the SOAP format. It was rare to find notes written by other disciplines, e.g., one entry by OT, one by the dentist, and two entries by the physician. The facility needs to instruct all disciplines that they are to write, chronologically, in the integrated progress notes as required by the SA and HCG for compliance.<br><br>As a result of the above failure for nursing to develop an Acute Care Plan for individual #138, the CNE conducted an immediate corrective action and called a meeting on 04/01/10 with will all nurse managers and case managers and on Documenting Medical and Nursing Concerns to resolution. Monitoring team members attended the meeting and retained minutes of the meeting.<br><br>Review of individuals '#s 138, 568, 409, 335, 419, 496, and 569's Medical Care Plan Monthly Review Notes, 02/10, indicated that nursing completes monthly notes that assess the progress and efficacy of health related interventions. Nursing Service Objectives were reviewed and continued with no change unless otherwise indicated in the narrative. Acute episodes, of illnesses, injuries, medication changes, hospitalization or infirmary admissions, and other pertinent health related information were consistently documented in the integrated progress notes. The general impressions of the Medical Care Plan Monthly Review Notes seem more comprehensive and substantive than those contained in the Annual and Quarterly Nursing Summaries. Further review will be conducted related to these notes in future tours and content will be compared with Nursing Annual and Quarterly Summaries for continuity. | |
| 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. | DSSLC's Nursing department has recently developed and implemented numerous nursing policies, procedures and protocols, as listed in the above documents. They were thoroughly reviewed and found to be in alignment with the current acceptable professional standards of nursing practice defined in the Settlement Agreement (SA) and Health Care Guidelines (HCG). The Lippincott Manual of Nursing Practice, fourth edition and Mosby's Clinical Nursing were used as references. As these policies, procedures, and protocols mature and are followed it is expected that nursing care will continue to demonstrate improvement.<br><br>The nursing department needs to continue to review, revise and/or develop and implement additional policies, procedures and protocols for Annual and Quarterly Nursing Assessments, Emergency Medical Response (Code Blue), Documentation (as related to nursing legal/liable aspects for documentation), Skin Integrity Management, and Pain Management. In addition, policies, procedures and protocols need to be developed and implemented for a variety of conditions unique to individuals with intellectual and developmental disabilities (DD), i.e., Down's Syndrome, as well as for chronic conditions commonly found in the DD population, i.e., Osteoporosis, Diabetes, GERD, Hypertension, Aging, etc. The Nursing department needs to ensure that all | |

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| | | policies, procedures, and protocols are in alignment with currently accepted standards of nursing practice and requirements of the SA and HCG. Once that is accomplished, the department needs to develop and implement associated monitoring instruments to ensure that quality care is provided and these practices are adhered to consistently. | |
| 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. | DSSLC was using the Health Risk Assessment Tool-Nursing Section as the tool for the identification of clinical risk indicators for individuals. The Health Risk Assessment procedure was of concern due to the fact there were no specific and/or clear criteria for determining risk levels The tools asked "yes" or "no" questions for items relating to Cardiac, Constipation, Dehydration, Diabetes, GI Concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. This Health Risk Assessment Tool was not adequate to provide a comprehensive risk assessment for any of the areas listed above, nor did it result in an appropriate identification of clinical risk indicators. The facility did use the standardized BRADEN Scale for assessing skin integrity issues. Professionally recognized standardized health risk assessment tools should be used statewide in all facilities to ensure that accepted professional standards of practice were followed. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria for determining risk to eliminate subjectivity, and to ensure that the Tool meets accepted professional standards of care.<br><br>The facility' Infection Control Department had one Infection Control (IC) Nurse who reports to the Chief Nurse Executive (CNE). A comprehensive Infection Control Manual has recently been developed and implemented. The infection Control committee was comprised of the following clinical and administrative staff: Medical Director, Pharmacy Director, Chief Nurse Executive, Infection Control Nurse, Nursing Operation Officer, Quality Assurance Nurse, Wound Care Nurse, Nurse Managers, Lead Dental Hygienist, Director, Assistant Director for Programming, Active Treatment Director, Director for Risk Management, Food Services Director, and, Housekeeping Supervisor. Infection Control Committee met quarterly and reviewed all aspects of infection control and made recommendations for corrective action, established due dates, status of issues discussed and acted upon, and assigned a responsible person to tasks. This was validated through review of IC Committee minutes.<br><br>The IC Nurse developed and implemented Infection Control Teaching and Information Sheets (as listed above in the documents). Trainings information sheets were made accessible to the nurse managers and RN case manager to use in training staff nurses, DCPs and other relevant staff. They used the appropriate training sheet each time an antimicrobial is prescribed. Instructions for training staff included:<br>• Obtain disease information sheet from area Nursing Office.<br>• Licensed nurse to in-service all staff on affected apartment and have them sign the | |

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| | | in-service form.<br>• Place disease information sheet on the Supervisor's Log book behind the health information tab.<br>• Retain the in-service sheet with the 24 Hour Report until staffs from three consecutive shifts have signed.<br>• Coverage RN on the following 6-2 shift will deliver the signature sheet to direct care supervisor on the apartment and to the RN attending the IRT meeting.<br>Review of copies of IC training material and accompanying signed in-service sheet, July, 2009 through January, 2010, were reviewed and validated that multiple training sessions occurred for the following infectious diseases: Influenza, Handwashing, Respiratory Hygiene, Standard Precautions, MRSA, Strongyloides (roundworms) on campus, Conjunctivitis, Bronchitis and Upper Respiratory Infection, Nasopharyngitis, Urinary Tract Infection, Herpes Simplex, and G-tube Abscess. This issue will continue to be reviewed in future tours. The IC nurse needs to develop and implement a training sheet for impetigo. Review of the Drug Utilization Report-Antibiotic Report, 03/17/10, indicated that individual #698 was treated and resolved for impetigo.<br><br>Review of the Monitoring Tool for Handwashing, July though December, 2009, validates that all disciplines are routinely monitored. The monitoring results were summarized and reported to the IC Control Committee. Review of the IC Committee minutes demonstrated handwashing compliance:<br>**October Quarterly Report 2009**<br>**Discipline** / **Monitored** / **#Adequate** / **Percentage**<br>Nursing: 9 / 7 / 77%<br>DCP: 82 / 75 / 91%<br>Resp. Therapist: 2 / 2 / 100%<br>Physicians: 2 / 2 / 100%<br>Totals: 95 / 86 / 91%<br><br>**January Quarterly Report 2010**<br>**Discipline** / **Monitored** / **#Adequate** / **Percentage**<br>Nursing: 51 / 50 / 98%<br>DCP: 90 / 72 / 80%<br>Resp. Therapist: 90 / 72 / 80%<br>Physicians: 60 / 60 / 100%<br>Totals: 291 / 254 / 90%<br>Review of the IC Committee minutes for the above quarters made recommendations for improving handwashing. The facility needs to continue to aggressively monitor handwashing because hand washing between the cares of individuals is the most effective means to prevent the spread of infectious diseases, especially MRSA. | |

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| | | There were no Environmental Surveillance Monitoring data available for review. Environmental Surveillance Monitoring is a vital component of infection control Review of the Environmental Review Team Committee minutes did not include information regarding environmental infections control issues.<br>Review of the Communicable Diseases Reports indicated that infections data were reported by individual, unit, infectious disease, and antibiotic therapy through to resolution. This information is summarized into the Drug Utilization Report – Antibiotic Cumulative Report. The Infection Control Committee reviewed and discussed the information and took action as indicated. The facility does not have formalized system for analyzing and trending infection control data. The IC nurse reported that the quarterly Medical Management Committee looks at trends using a Root Cause Analysis approach and takes corrective action as indicated. Medical Management Committee minutes were not available for review. This issue will be reviewed on future tours. The Infection Control Committee needs to develop and implement a system to analyze and trend data to use as clinical indicators in managing infectious diseases.<br><br>Review of the Communicable Disease Report, 03/08/10 through 3/25/10, identified four individuals with reportable infectious diseases, including three treated for MRSA (Individuals #216, #279, and #263) and one treated for C. Diff. (Individual #419).Review of the Positive PPD and CXR List indicated that all TB converters were tracked and follow-up according to health department guidelines. Records for individuals diagnosed with reportable infections will be reviewed at the next tour.<br><br>Review of the Pneumonia Tracking Sheet, February, 2009 through March 2010, indicated there were 131 diagnosed cases of pneumonia (may include duplicate individuals). There was a total of 30 cases of pneumonia diagnosed with aspiration pneumonia (18 cases were in individuals nourished via tube and 12 were orally fed), 11 cases were diagnosed as bacterial, and 90 diagnosed as other. The CNE related that often the individuals acquired pneumonia while in the hospital. There was also difficulty with physicians specifying the type of pneumonia. The IC nurse reported that 100% of individuals who required pneumococcal vaccination were vaccinated. In an effort to better understand the cause of the high incidents of pneumonia and to implement preventative strategies, the CNE was assembling a work group from all disciplines to perform a Root Cause Analysis and Failure Mode Effect Analysis of pneumonia prevention. The results of this work group's study will be reviewed at the next tour.<br><br>Review of the List of Persons with Skin Breakdown, March 30, 2010, indicated three who acquired Stage IV and two who acquired Stage II decubitus ulcers during stays at hospitals and long term care facilities.<br>Because of the high incidents of hospital acquired decubitus ulcers the CNE, Infection | |

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| | | Control Nurse and Hospital Liaison Nurse needs to work collaboratively with the OT/PT department, PST, HST, and local hospitals to determine why individuals were developing decubitus ulcers while in the hospital and develop and implement strategies to prevent such occurrences. The nursing staff needs to complete a full body skin assessment and document findings before and after hospitalization.<br><br>The Infection Control department maintains a Client Immunization Report on a database that provides individuals' immunization status. The database did not contain a due date for immunizations required periodic revaccination according to CDC guidelines. The IC nurse reported that the nurse case managers track immunization status and need for routine preventative health exams, laboratory/diagnostic tests; then informs physicians when such items were due. The facility's Infection Control database needs to add projected due dates for immunizations that require periodic revaccination according to CDC guidelines. | |
| M6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | Medication Administration and Enteral Nourishment Observations were completed at the 4:00 p.m. medication pass in 515B. Because of limited space medication was passed in the day room. The staff nurse afforded individuals privacy by use of a privacy screen. The DCP staff assisted the nurse by bringing individuals to the med cart for medication and enteral nourishment. Because of the high incident of pneumonia and other infections the nurses checked each individual's vital signs and $O_2$SATS. According to the CNE, vital signs and $O_2$SATS were routinely completed each shift during medication administration. The Medication Administration Records (MARs) contained a pink sheet printed by the pharmacy of all medications ordered. These sheets were utilized to track the number of medications remaining after taking out each medication. This measure was implemented to reduce medication errors/omissions. In addition, MARs contain Special Instruction sheets regarding liquid and food consistency/texture, positioning, adaptive equipment, etc. Mother Care spoons were used for medication administration that required mixing medicine with pudding, etc., to ensure safe administration of medication.<br><br>The monitoring team observed a staff nurse successfully administering medications and enteral nourishment according to accepted professional standards. During the course of passing medication it was discovered that individual #65'sliquid consistency requirement for honey consistency was not on the Special Instruction sheet. The nursing case manager was notified immediately with a request for correction on the instruction sheet. Individual #438 was resistant to taking liquid milk of magnesia (MOM). Because of individual 65's aversion to the liquid form of MOM but had the ability to swallow pills, the nurse case manager was requested by the staff nurse to contact the physician for an order to change MOM to pill form. | |

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| | | Reviewed sample from the March, 2010 MARs for individuals #337 and 267. The review indicated that the "pink sheets" to track medication usage were not consistently completed each shift, each day. Individual #337's March, 2010 Self Administration data sheet revealed that the data were inconsistently recorded. Medications administered as per necessary (PRN) did have their administration and therapeutic response documented on the back of the MAR. The Nursing department needs to develop and implement MAR monitoring procedures to track and trend data to improved medication administration practices, documentation, and prevent medication errors. The trend data needs to be included in Nursing Management Meetings, Medication Error, and Pharmacy and Therapeutic Committees.<br><br>One full time QA Nurse III observes quarterly medication administration passes for all nurses who routinely passed medications. The information was compiled into a spreadsheet and shared with the Chief Nurse Executive (CNE), nurse managers, and the nurse educator. Retraining was conducted on the spot when needed and information shared. If there were any significant issues the nurse was observed a second time. In addition to medication observations this QA Nurse III also completed chart reviews. The results were placed into the QA Monitoring folder online for Professional Improvement Committee (PIC) members to review and discuss at the monthly PIC meetings.<br><br>Review of the QA department's Medication Observation Tools, completed for January and February, 2010, related to SA Section M.6, indicated that the tools met acceptable standards of professional practice and were in alignment with the SA and HCG. The results are scored by a percentage of compliance for each item with an overall percentage total of compliance. Overall scores of compliance ranged from 88% to 100%. Items most often identified as falling below 100% compliance included: 1. Nurses failed to follow current infection control precautions throughout the medication pass. 2. Medications were opened, already mixed in pudding, etc., or already poured into container prior to beginning the medication pass. 3. Nurses failed to check the medication label against the MAR three times before administering the medication to the individual. 4. Nurses failed to call the first and last name of individuals and get verbal verification from the individual, staff, or another nurse prior to administering the medication. 5. Nurses failed to provide the individual privacy during medication pass. Further review of the Medication Administration Observation Tools contained comments describing deficiencies, identification of the nurses who committed the deficiencies, and provided recommendations for remedial action. The results of the monitoring tools as well as spreadsheets were sent to the RN unit managers and nursing administration.<br><br>The Nursing department performed few routine internal medication observation passes. | |

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| | | The Nursing department's nurse managers or designated nurses need to consistently conduct internal medication observations passes at least quarterly, utilizing the QA department's Medication Observation Pass Tools to ensure continuity, promptly identify deficiencies, and take remedial action when indicated.<br><br>The facility's Medication Errors Policies and Procedures were based on the National Council for Medication Error Reporting and Prevention guidelines. Medication errors are classified by the Medication Error Categories/Severity Index used to standardize the level of patient impact caused by medication errors. These categories classify an error according to severity of outcome by considering factors such as whether the error reached the individual, if the individual was harmed and, if so, to what degree. Categories range from lesser to greater severity, e.g., Categories A through I. Review of the facility's Medication Error Reports, 07/06/09 through 02/25/10, reported into the "WoRX" computerized system, indicated that a total of fifty-seven errors were reported. Reported medication errors are described below:<br>• Thirty-two of the errors were classified as category A (Neither error or harm occurred. The circumstances or events only had the *potential* to cause an error). According to the explanation found upon investigation: Three were due to documentation errors, two were due to transcription errors, one was due to a communication error, and one was identified as other.<br>• Twelve were classified as category B (An error occurred but the medication did not reach the individual).<br>• Thirteen errors were classified as category C (An actual error occurred. The error *reached* the individual. The individual was *not* harmed by the error). According to the explanation found upon investigation: Both errors were due to administration errors.<br>A total of 57 medication errors were reported in the above report for an eight month period. Errors reported were primarily related to pharmacy dispensing errors. There was evidence in each Medication Error Report that prompt corrective action was taken.<br><br>Starting in December, 2009, the Medication Error Committee changed from monthly meetings to weekly due to an increase in medication errors. It is plausible to wonder if there was underreporting of medication errors up to that point. Medication errors are reported by the Medication Error Committee in graphic form. It was difficult to interpret without instructions. Medication error data needs to include all medication errors committed by all disciplines responsible for medication administration. Data need to be represented in a straight forward system to analyze, track and trend clinical data for medication errors. This data need to be used to develop interventions to prevent or reduce medication errors. Data findings need to be included in the Nursing Management Meetings, Medication Error Committee, and Pharmacy and Therapeutic Committee | |

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| | | meetings.<br><br>DSSCL's Self Administration of Medication (SAM) Policy and Procedure requires nurses to train individuals and collect data with each medication pass. Review of individuals #138, #568, #409, #335, #419, and #569s' SAM data sheets were not consistently completed with each medication pass as required by facility policy and procedures. The Nursing Department needs to ensure that nurses follow the SAM policy and procedure for completing individuals' SAM program with documentation of data at each medication pass.<br><br>Review of individual #335's 10/09 MAR listed "give H1N1 0.5 milliliter (ml) intramuscularly (IM) in the month of December"; the MAR was not initialed whether or not this vaccine had been given. The Nursing department needs to review #335's records to determine whether the H1N1 vaccine was administered. Additional review of MARs and Daily Active Treatment Specialist Records indicated missing initials without circles or explanations on one or more occasions for the 12 different medications or treatments.<br><br>The failure to document was a significant finding. The Nursing department needs to review #335's MARs dates and times to determine whether medication errors of omission were committed as well as a medication error related to the daily use of Selsun blue 1% shampoo as applied by DCPs. The Nursing department needs to increase monitoring of MARs and Daily Active Treatment Specialist Records for medication errors and/or omissions.<br><br>Review of individual #496's MARs indicated missing initials without circles or explanations on one or more occasions for nine medications.<br><br>The failure to document the above information was a serious finding. The Nursing department needs to review #496's MARs dates and times to determine whether medication errors of omission were committed.<br><br>Review of individual #569's MARs indicated missing initials without circles or explanations on one or more occasions for 13 medications. In addition, the following treatments and checks were not documented as performed:<br>• Residual checks every shift, amount were not recorded on 10-6 shift on 02/04/10, 02/06/10, 02/09/10, 02/26/10; 02/27/10; on 6-2 shift on 02/16/10; and on 2-10 shifts on 02/15/10.<br>• Every shift and PRN – rotate tube within stoma and burp was not initialed on 02/15/10 on 2-10 shift and 02/16/10 on 6-2 shift. | |

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| | | • Intermittent Pump: Jevity 1.5 225cc with 125 cc water was not initialed on 01/14/10 at 0730 and 1130; 01/31/10 at 1530 and 1930; and 02/14/10 at 1930.<br>• Bolus Instructions: 225 cc Jevity 1.5 (Total 900cc/day) was not initialed on 02/15/10 at 1530 and 02/16/10, 02/22/10, 02/23/10, 02/24/10, 02/25/10, and 02/26/10 at 0730 and 1130.<br>• Water 125cc (Total 500/day) was not initialed on 02/15/10, 02/16/10, and 02/22/10 at 0730; 02/15/10, 02/16/10, and 02/22/10; at 1130; and 02/15/10 at 1530.<br>The failure to document the above information was a serious finding. The Nursing department needs to review #569's MARs and Enteral Feedings Administration Records for the above medications and feedings, date and times to determine whether medication or feeding errors of omission were committed.<br><br>Review of Daily Active Treatment Specialist Records, September, 2009 through February, 2010, reveal too numerous omissions in charting to specify. The omissions include the following items:<br>• Elevate feet on hour three times a day;<br>• Bedrails in place and bumper pads when in bed (when pad are in need of repair may use body pillow till pads are available);<br>• Elevate feet when setting or lying;<br>• When out of wheelchair keep body on angled surface elevated at all times; and<br>• Elevate head (of bed) six inches.<br>The failure to document the above information was a significant finding due to #569's risk for skin breakdown. The Nursing department and/or responsible DCP supervisors need to monitor Daily Active Treatment Specialist Records to ensure that all prescribed treatments are completed and documented.<br><br>Review of the past six months Initialing Accountability MAR Sheets were not consistently completed daily by shift. The purpose of this sheet was to readily identify if there was an overage or underage number of prescribed medication in an effort to prevent or reduce medication errors. The Nursing department needs to retrain nurses administering medications to complete the Initialing Accountability MAR Sheets. | |

**Recommendations:**

1. The facility's Nursing department's nursing staff needs to ensure that instructions communicated to DCP on the Home Shift logs are documented in the integrated progress notes. Nursing staff needs to verify that instructions to the DCP were carried as instructed.
2. Because of the high risk for choking and aspiration, leading to aspiration pneumonia, in this population nursing needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by the nurses.
3. The facility's Nursing department's Hospital Liaison Nurse needs to place hard copies of individual's hospitalization documentation chronologically in the integrated progress notes to ensure continuity of care.

4. The facility's QA department needs to cross-walk the recently developed monitoring tools with the SA and HCG to ensure that all areas required for compliance are addressed.
5. The facility's QA department's Chart Review Monitoring Tools that have "double barreled" questions need to be reviewed and revised into two or more questions in order to provide for an accurate response.
6. The facility's QA department's monitoring tools needs to address quality of care provided by clinical disciplines and make recommendations for corrective action.
7. The facility's QA department needs to analyze, track and trend clinical performance data to identify areas of practice and to ensure that non-compliant practices demonstrates improvements.
8. The facility's Nursing department needs to develop and implement an effective internal peer review process.
9. The facility's Nursing department needs to routinely monitor Control Check Sheets and Equipment Checklists to ensure they are checked and signed by nurses every day and every shift.
10. The facility's unit emergency equipment needs to be placed on an emergency cart for ready and rapid transport.
11. The facility needs to evaluate the Emergency Management Response system to ensure:
    - Emergency Medical Response Policies and Procedures are in place and meet acceptable standards of professional practice;
    - Physicians, nurses, and other ancillary personnel responsible for responding to medical emergencies participate in Mock Medical Drills;
    - All personnel required to maintain CPR certification are up-to-date;
    - Mock Emergency Medical Drills are reviewed in the Risk Management Committee with minutes reflecting the discussion and any corrective action taken;
    - Each failed drill includes a statement of corrective action to be taken;
    - The committee needs to analyze, track, and trend outcomes and recommendations for corrective action; and
    - The QA department monitors all aspects of emergency management response.
12. The facility's Nursing department's nurse managers or designated nurses' needs to conduct internal medication observations passes at least quarterly, utilizing the QA department's Medication Observation Pass Tools to ensure continuity, promptly identify deficiencies, and take remedial action when indicated.
13. The facility's Nursing department needs to ensure that Control Check Sheet and Equipment Checklists are checked and signed by nurses every day and every shift.
14. The facility's Nursing department needs to continue to review, revise and/or develop and implement additional policies, procedures and protocols for Annual and Quarterly Nursing Assessments, Emergency Medical Response (Code Blue), Documentation (as related to nursing legal/liable aspects for documentation), Skin Integrity Management, and Pain Management. In addition, policies, procedures and protocols need to be developed and implemented for a variety of conditions unique to individuals with intellectual and developmental disabilities (DD), i.e., Down's Syndrome, as well as for chronic conditions commonly found in the DD population, i.e., Osteoporosis, Diabetes, GERD, Hypertension, Aging, etc.
15. The facility's Nursing department needs to ensure that all policies, procedures, and protocols are in alignment with current accepted standards of nursing practice and requirements of the SA and HCG. Once that is accomplished, the department needs to develop and implement associated monitoring instruments to ensure that quality care is provided and these practices are being adhered to consistently.
16. The facility's Nursing Department's nursing case managers need to continue to strengthen comment sections and summaries in their Annual and Quarterly Nursing Assessments to include whether the individuals' health status were progressing, maintaining, or regressing, strategies that are working or not working, and to recommend changes, if indicated, in strategies, support and/or services.
17. The facility's Nursing department needs to ensure that all units/nurses have otoscopes and other diagnostic equipment available and in good working order to complete physical assessments.
18. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria for determining risk to eliminate subjectivity, and to ensure that the Tool meets accepted professional standards of care.

19. The facility's Infection Control nurse needs to develop and implement a training sheet for impetigo.
20. The facility's Infection Control Committee needs to develop and implement a system to analyze and trend infection data to use as clinical indicators for managing infectious diseases.
21. The facility needs to continue to aggressively monitor handwashing because hand washing between the cares individuals is the most effective means to prevent the spread of infectious diseases, especially MRSA.
22. The facility's Infection Control department needs to ensure routine Environmental Surveillance Monitoring is completed according to policy.
23. The facility's Infection Control department's database needs to add projected due dates for immunizations that require periodic revaccination according to CDC guidelines.
24. Because of the high incidents of hospital acquired decubitus ulcers the facility's CNE needs to work collaborative with the OT/PT, PST, HST, and local hospitals to determine why individuals were developing decubitus ulcer while in the hospital, and develop and implement strategies to prevent such occurrences.
25. The facility's Nursing department's nursing staff needs to ensure that a full body skin assessment and document findings before and after hospitalization.
26. The facility's Nursing and Pharmacy departments needs to develop and implement a system that includes all disciplines responsible for medication administration to analyze, track and trend clinical data for medication errors. This data needs to be used to develop interventions to prevent or reduce medication errors. Data findings need to be included in the Nursing Management Meetings, Medication Error Committee, and Pharmacy and Therapeutic Committee meetings.
27. The facility's Nursing department needs to develop and implement MAR monitoring procedures to track and trend data to improved medication administration practices, documentation, and prevent medication errors. The trend data needs to be included in Nursing Management Meetings, Medication Error, and Pharmacy and Therapeutic Committees
28. The facility's Nursing Department needs to ensure that nurses follow the SAM policy and procedure for completing individuals' SAM program with documentation of data at each medication pass.
29. The facility's Nursing department needs to include signature and date lines on the HMPs that ensures that they are reviewed and/or revised at the time Quarterly Nursing Assessment are completed.
30. The facility needs to instruct all disciplines that they are to write, chronologically, in the integrated progress notes as required by the SA and HCG for compliance.
31. The facility's Nursing department needs to retrain nurses administering medications to complete the Initial Accountability MAR Sheets.
32. The Nursing department and/or responsible DCP supervisors need to monitor Daily Active Treatment Specialist Records to ensure that all prescribed treatments are completed and documented.
33. The facility's HST needs to aggressively develop and implement additional strategies to promote weight loss for individuals' #s 335 and 496.
34. The facility's Nursing department needs to review their Annual and Quarterly Nursing Assessment Policy and Procedures and report forms to ensure the inclusion of SAM information.

| **SECTION N: Pharmacy Services and Safe Medication Practices** | |
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| Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Policies and procedures regarding pharmacy services,<br>2. Policies and procedures regarding medication administration<br>3. Procedures regarding medication error/variances including prescription, dispensing, administration, documentation and potential errors.<br>4. HCG Appendix A: Pharmacy and Therapeutics Guidelines<br>5. Pharmacy tools for medication administration audit tool.<br>6. QDRRs, and DISCUS reviews : Individual #67, #79, #90, #91, #127, #138, #151, #163, #222, #228, #l #229, #230, #236, #26 #5, #297, #306, #359, #373, #374, #393, #399, #413, #457, #482, #493, #511, #512, #522, #539, #562, #579, # 629, #638, #659, #689, #681, #720, #766, #781<br>7. DSSLC Drug Order Reports – all psychotropics, anticonvulsants used for neurological indications, for behavioral indications, and for behavioral and neurological indications<br>8. Reviewed listing of medication pass times.<br>9. Reviewed listing of enteral medication pass times.<br>10. Single Patient Intervention Report example on individual # 522<br><br>**People Interviewed:**<br>Rosha Chadwick, R.Ph. Director of Pharmacy (two meetings).<br><br>**Meetings Attended:** See section J |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor Assessment:**<br><br>The pharmacy established procedures for safe medication practices to assure that a pharmacist will review newly prescribed medications and will review with physician and other providers any potential interactions or contraindications to the use of those medications. Pharmacists provided ongoing communication with clinicians about possible drug/drug interactions prior to and throughout the course of medication administration.<br><br>QDRRs were completed with comments/recommendations, when indicated.<br><br>Pharmacists participated in HST meetings. These meetings provided an opportunity for presentation of QDRR findings and meaningful discussion of findings with clinicians. |

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| | Several facility committees reviewed issues that related to pharmacy practices. These included P&T, Pharmacy Consultation, Psychiatric Polypharmacy and Medication Error Committees.<br><br>The Settlement Coordinator reviewed the Plan of Improvement (POI), and identified areas where enhanced use of the TAC could improve analysis of drug utilization patterns. |

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| N1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature. | The Director of Pharmacy reviewed the system in place for review of new medications. Once an order was received the pharmacist reviewed the orders using standard data bases which included WORx and microdex. When needed, additional databases were consulted, such as the National Library of Medicine database. The pharmacist also reviewed orders with knowledge of the clinical circumstances of the individual, including drug allergies and sensitivities. When potential difficulties were noted, they were listed as mild, moderate, or severe. A communication was then provided back to the prescribing clinician. The communication was by telephone and/or secure email. When necessary, medication orders were modified and a new order sheet generated for the clinical record. Documentation of communications between the prescriber and the pharmacist were retained by use of "Single Patient Intervention Report." These listed the staff interactions around the care of a particular individual on a particular date. Information listed includes details of the medication, the category and subcategory of the compatibility interaction, recommendations made to the prescriber, the response of the prescriber, and the outcome of the review. For example, in the case of individual # 522, on 02-05-10, the pharmacy documented a possible interaction, between an antibiotic and a medication the individual received. The Single Patient Report documented the conversation between the pharmacist and the physician, and the decision to change treatment to use an alternative antibiotic for which there was no interaction. | |
| 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. | Detailed QDRRs were completed. These listed list lab results appropriate to the review circumstances | |
| 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 | Per N1 above – in the example provided for the Single Patient Intervention Report provided by the Director of Pharmacy, three providers collaborated on the interaction with the pharmacist. Collaboration between providers was commonly noted in the QDRR process: Providers commented on findings in written chart comments, and discussion between HST members regarding QDDR findings were witnessed during the HST meeting attended by the monitor. | |

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| | 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. | | |
| N4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed. | Per N1 above, regarding the care of particular individuals in real time. The Director of Pharmacy also reviewed the manner in which facility committees were utilized to provide physician -pharmacist review of medication utilization patterns. For example, the Director of Pharmacy shared information about the analysis provided on facility-wide utilization of olanzapine (Zyprexa) and clonazepam (Klonopin). The Director of Pharmacy reviewed the method in place under which if there was a disagreement between the pharmacist and the prescribing PCP as to the propriety of a medical order, the pharmacist could refer the matter to the Medical Director. No such event had occurred in recent memory, according to the Director of Pharmacy. | |
| 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. | Slight differences in wording between SA N.,5 and HCG, III C 1g3 were discussed with the CNE, who clarified that DISCUS reviews were done on a quarterly basis, and MOSES reviews were done every six months | |
| 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. | Interactions between the pharmacist and medical staff took place on many levels. Adverse medication responses were reviewed at clinical rounds, for example daily infirmary rounds. Nurses completed MOSES and DISCUS forms, discussion took place at HST meetings, and further reviews were done at Pharmacy and Therapeutic Committee meetings. Procedures for notification of FDA and others per routine clinical practice were reviewed with the Director of Pharmacy, and standard guidelines were provided via DADS and discussed in the DSHS/DADS Executive Formulary Committee. | |

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| | | Review of individual #s 409 and 335s' Annual and Quarterly Nursing Assessments indicated that the MOSES assessments were completed every six months and reviewed and signed by the physician. The Annual and Quarterly Nursing Assessments for #335 included nursing summaries indicating the individuals' therapeutic response to psychoactive medications but #409 did not contain such summaries. Nurses need to develop and implement HMPs for individuals receiving psychoactive medications with individualized goals and interventions. The HMP needs to include instructions for DCPs regarding specific side effect monitoring of psychoactive medications. | |
| 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. | QDRRs reviewed elements that were consistent with elements required by SA. | |
| 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. | Medication variances were reviewed in the Medication Error Committee. Per the Director of Pharmacy, pharmacy staff attended committee meetings. Additional opportunities to review patterns of any variances were identified. These included P&T, Pharmacy Consultation and Oversight, and Psychiatric Polypharmacy Committees, and the DSHS/DADS Executive Formulary Committee. | |

**Recommendations:**

1. Nursing Administration should review the SA and HCG in order to understand and develop strategies to meet compliance with SA II. J.,9 – Psychiatric Care and Services : Sections 9 ( IDT integration of treatment; SA II., G., - Integrated Clinical Services: Section 1 ( integrated clinical efficacy); 5 (monitoring of health status of individuals and 6 (treatment modified in response to clinical indicators, and HCG III Psychotropics/Positive Behavior Support.
2. The broad determination as to the relative risk of polypharmacy, as addressed in QDRRs, and HSTs is not sufficiently detailed. Psychiatrists should also indicate why a particular polypharmacy regimen is needed, on a case-by-case basis. This issue is also addressed I section J of this report.
3. The facility's nursing case managers need to develop and implement HMPs for individuals receiving psychoactive medications with individualized

goals and interventions. The Nurses need to develop and implement HMPs for individuals receiving psychoactive medications with individualized goals and interventions. The HMP needs to include instructions for DCPs regarding specific side effect monitoring of psychoactive medications.

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Record Reviews of Individuals #703, #11, #633, #163, #416, #768, #766, #536, #552, #499, #496, #453, #672, #19, #392, #589, #524, #118, #245, #449, #327, #364, #44, #574, #240,#1, #248, #326, #329, #776, and #509.<br>2. Review of requested tour documents including but not limited to:<br>a. Risk lists associated with skin breakdown, falls, pneumonia, choking, weight loss and weight gain<br>b. Occupational and Physical therapy Assessments<br>c. Nutritional Management Meeting (NMT) minutes 12/2008 to 3/2010<br>d. Physical and Nutritional Management Plan (PNMP) clinic minutes 03/2009 to 03/2010<br>e. HST minutes 2/2009 to 3/2010<br>f. Nutritional Management Risk Tool<br>3. Reviewed the applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management<br><br>**People Interviewed:**<br>1. Donna Groves OTR, Director of Habilitation Services<br>2. Joy Sibley SLP, Director of Communication Therapy<br>3. RN Case Managers present at RN Case Managers Meeting<br>4. Dr. John Beall RN, Chief Nurse Executive<br>5. Sherry Courtney RN, Operations Nurse<br>6. Sibylle Graviett, RN, RN Case Manager Leader<br><br>**Meetings Attended/Observations:**<br>1. Observations of 503b, 522b, 512b, 513b, 502c, 502d, 514b, 513a, 522a, 522c, 522d living areas and dining rooms.<br>2. Health Status Team (HST) quarterly 3/30/2010<br>3. NMT meeting 3/31/2010<br>4. RN Case Managers Meeting<br>5. Positive Behavior Support Committee 4/1/2010<br>6. PNMP clinic 3/31/2010 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Individuals who are at a "high risk" are not being identified and therefore may not be receiving the care and treatment required to prevent future illness. While most individuals have a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene, medication administration, behavioral information, and |

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| | signs and symptoms associated with aspiration or decline not being included as part of the document. Additionally, the assessment process involved in the development of the PNMPs is flawed secondary to little input being provided by therapy regarding oral hygiene techniques, water safety and presentation of medications.<br><br>Staff was not observed consistently referring to dining cards or PNMPs. Individuals are provided with care according to the PNMPs at best sporadically. Multiple situations occurred in which individuals were eating or positioned in a manner that may result in an increased risk of choking and or aspiration.<br><br>Overall, there needs to be more of a proactive, cooperative, collaborative, systemic approach to address physical and nutritional support issues. |

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| O1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional | Although DSSLC has a PNM team that meets as part of the HST, the team's scope is too limited and narrow; it does not proactively and comprehensively address the wide ranging needs of the individuals. The team consists of an occupational therapist, Psychiatrist, Psychologist, QMRP, nurse, and physician. The team focuses primarily as a medication and medical health status review and does not address the individualized physical needs and concerns of the individuals.<br><br>A nutritional management team does exist and consists of the Habilitation Services Director, RN, QMRP, RD, MD, and various other professionals and staff. The focus of this meeting is primarily on the nutritional aspects of physical and nutritional management. Additionally, there is little to no speech therapy involvement secondary to staffing issues.<br><br>A PNMP clinic does exist and meets weekly consisting of the caseload OT, PT, OT assistant, Wheelchair Director and PNMP coordinator. In contrast to the nutritional management team, this team focuses primarily on the physical aspects of physical and nutritional management. Once again, there is little to no speech therapy involvement due to staffing issues.<br><br>As previously stated, there was little active involvement by the speech pathologist in the PNMP clinics, Nutritional Management team meetings or HST meetings as there are only 2.5 therapists available for the entire campus. Additionally, there did not appear to be a process in place to ensure collaboration between the parties.<br><br>The result of having multiple teams with multiple meetings results in a fragmented system with no team that covers all physical and nutritional components of care.<br><br>DSSLC does have physical and nutritional management plans (PNMP) in place for all | |

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| | management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. | individuals with PNM supports; however, the PNMP is lacking information concerning oral care strategies, medication administration, and signs and symptoms associated with aspiration. Additionally, the PNMP is not fully integrated into the individual's Personal Support Plan (PSP). Currently, the PSP only references PNM supports and does not include information regarding the reliance on such interventions and how they improve the individuals' life. | |
| 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 | Many individuals who live at DSSLC have medical conditions that seriously complicate the swallowing and digestion of their food and beverages as well as increase their difficulty in being able to safely manage their oral secretions.<br><br>Aspiration Pneumonia is often a preventable condition that results from the accumulation of foreign materials (usually food, liquid, or reflux) in the lungs. DSSLC lists only 29 individuals as at "high risk" for aspiration and two individuals who are at "high risk" for choking. Several individuals who do not appear on the center's high risk list were hospitalized for aspiration or choking related events or identified through videofluoroscopy or by team members as having symptoms drastically increasing the risk of aspiration. Based upon observation, there were a significant number of individuals who were observed to be at "high risk" but were listed as being at "low risk" according to their screening forms.<br><br>Thorough review of the "At Risk" policy revealed multiple issues. One was that the center was incorrectly following the policy as DSSLC was placing the majority of their individuals as being at "low risk" when they should have been placed as at "medium risk." Second, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they | |

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| | management problems to identify the causes of such problems. | require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. Following the policy as written would result in DSSLC having the majority of its population listed as "Medium Risk" since most of the individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at DSSLC.<br><br>Overall risk is determined primarily by the physician and does not frequently follow guidelines set forth by DSSLC. For example:<br>• Individual #364 had a choking event within 30 days of the HST meeting; however, the risk level assigned was "Medium" instead of "High" as stated in the risk guidelines.<br><br>Examples that the current system was not accurately identifying those who are at risk include:<br>• Individual #633 has a diagnosis of gastritis, hiatal hernia, Barrett's Esophagus, and Schatzkis B ring; however, was listed as being at a "Low Risk" of aspiration/choking and GI issues<br>• Individual #766 has a diagnosis of GERD, hiatal hernia, esophagitis, and aspiration pneumonia; however, the individual was listed as being at a "Low risk" of aspiration/choking and GI issues<br><br>Identification of skin breakdown risk was also not adequately identified. For example:<br>• Individual #496 had episodes of skin breakdown on multiple body parts occurring on 2/15/09, 3/16/09, 7/13/09, 8/25/09, 10/1/09, 11/12/09, and 11/16/09; however, is not listed as being at a "High risk" for skin integrity.<br>• Individual #19 had episodes of skin breakdown occurring on 1/30/09, 5/14/09 and 8/18/09; however, is listed as being "low risk" for skin breakdown.<br><br>As with Aspiration; falls are not being adequately categorized as it relates to risk. For example:<br>• Individual #703 had falls occurring on 1/3/10, 1/30/10, and 2/1/10 but was listed as being at a "Low Risk" of Falls.<br>• Individual #163 had falls occurring on 2/4/10 and 3/4/10 and again was listed as being at a "Low Risk" of Falls<br><br>In addition to the issue noted above, there was no criterion that guides the team in determining level of risk that is based on information other than history of the condition. For example, an individual who has not had aspiration pneumonia in the past 6 months may be placed in a low risk category even though factors exist that would indicate a | |

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| | | higher risk and a need for special supports. Consideration is not given in the guidelines that focus on factors resulting in an increased risk.<br><br>Another issue was that there was no screening that focuses on pneumonia risk. Aspiration/Choking is screened; this screening does contain some components of pneumonia risk identification but the issues leading to an increased risk of pneumonia and choking often vary, thus making a single "catch all" screening very difficult to be highly accurate.<br><br>There is an additional screening tool called the "Nutritional Management Risk Tool" that is used during the assessment phase or referral process. This screening tool is utilized to help the PNM team determine each individual's level of risk. Risk indicators were categorized across three levels: High (Level1), Medium (Level 2), and Low (Level 3).<br><br>The Nutritional Management Risk Tool was too narrow in focus and did not adequately include physical management aspects that may impact health status. Additionally, the NMT screening and the screening forms for aspiration and choking as well as other screening related to Physical and Nutritional Management (i.e., Constipation, GI issues, etc..) are completed separately and follow two different processes for completion leading to an increased risk of fragmentation between areas of practice.<br><br>There was not a clear process in place in which the PNMP team is notified should a sign or symptom associated with aspiration occur. Currently, notification relies on DCPs determining an issue is severe enough to contact nursing then nursing determining an issue is severe enough to contact the physician and make a referral. This results in clinical judgments regarding PNM being made by individuals who are not clinicians and too many opportunities of signs and symptoms that are not overt to be missed therefore resulting in a more reactive than proactive approach. During several meals on 522b, 513b, 514a and 522a, coughing was observed but no interventions were provided and no referrals were made in response to these issues.<br><br>Individuals are not currently provided with what is considered to be a swallowing assessment. As of this review, DSSLC's OT/PT assessment contains an Oral Motor component but not a full assessment that measures function and status. For example:<br>• Individual #364 had a choking event on 3/8/10. In response to the incident, the individual received a general mealtime observation rather than a full tableside assessment.<br><br>Individuals are not provided with comprehensive assessments in response to significant events or changes in status. For example:<br>• Individuals #326, #776, #499, #711, #329, #248, 509 had incidents of | |

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| | | pneumonia. The incident was discussed at the NMT meeting but there is no evidence of assessment or follow up completed by Habilitation Therapies.<br>• Individual #703 had falls occurring on 1/3/10, 1/30/10, and 2/1/10; however there is no evidence that the individuals received an assessment or follow up by Habilitation Therapies.<br>• Individual #163 had falls occurring 2/4/10 and 3/4/10, however there is no evidence that the individuals received an assessment or follow up by Habilitation Therapies.<br><br>DSSLC only has 2.5 Speech Pathology positions filled and only three Dietitians. This results in increased difficulty addressing the swallowing needs as well as the nutritional needs of the individuals. Currently Speech Therapists and Dietitians are not sufficient in numbers to allow for active collaboration and participation in the nutritional management meetings or HST meetings. | |
| O3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties. | PNMPs have been developed for individuals residing at DSSLC; however, 31/31 PNMPs reviewed are inadequate as the risks associated with oral hygiene and oral medication are not addressed in the current format.<br><br>Currently, therapy (OT, PT, and SLP) has no role in developing oral hygiene plans or input into the method in which oral medication is provided. Oral management as well as positioning of person and staff associated with these two activities is essential to minimizing the risk of aspiration. Oral hygiene plans are currently developed only by nursing and the method in which medications are provided are determined solely by the physician. | |
| O4 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication | Based upon observations, it was noted that implementation of the dining cards or PNMPs are sporadic. For example:<br>• Individual #416 was observed not getting small bites.<br>• Individual #449 was observed eating without bowl guard.<br>• Individual # 453 was observed eating with no cues to swallow between bites or sips.<br>• Individual #658 was observed slid down and leaning to her right in a recliner when receiving enteral nutrition.<br><br>Based upon multiple discussions and observations with 513a and 522a DCPs, knowledge | |

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| | administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties. | regarding physical and nutritional management and supports were not evident. DCPs were unaware of the individuals' level of risk or the rationale behind many recommendations listed on the PNMPs and dining cards and how not following these recommendations would increase the level of risk.<br>Individuals identified as needing alternate positions are not provided with such interventions. For example:<br>• Per positioning schedule, Individual #552 and #392 should have been in a supine position however both were observed in left sidelying position.<br>• Per positioning schedule, Individual # 536 should have been in a right sidelying position but was observed in a supine position.<br>• Per positioning schedule, Individual #589 should have been in a right sidelying position but was observed in a supine position.<br><br>In addition to positioning schedules not being followed many individuals were observed poorly positioned in wheelchairs, bed, and/or recliner with no staff intervention. This poor positioning results in increased pressure points of the body and increased fatigue due to the body struggling to maintain proper alignment. For example:<br>• Individual # 118 was leaning to the right in his wheelchair.<br>• Individual #672 was slid down in her recliner and leaning to the right.<br>• Individual #416 was leaning to the right in his wheelchair.<br><br>Oral Care observations revealed minimal to no carryover of safe swallow strategies. Staff was observed providing thin liquids to individuals who required thickened liquids, individuals who utilize wheelchairs were consistently observed hyper-extending their neck due to poor self positioning and staff positioning thus increasing the opening of their airway and their risk of aspiration.<br><br>Individuals who are on modified diets (i.e., pureed and honey thick fluids) are provided at times with whole medications and are at times without the adaptive equipment specified in their PNMPs and dining cards for oral intake thus placing the individual at an increased risk during these activities. Prescribed adaptive equipment and texture modification should be implemented during all oral intake and not just mealtime due to swallowing being involved in both activities.<br><br>Once again, Habilitation Services clinicians should become more active participants in determining the positioning of the individual and staff during these activities and assist in determining the best method for presenting these two activities.<br><br>Individuals are being provided with enteral nutrition while in recliners resulting in poor positioning and increased risk of reflux aspiration. For example: | |

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| | | • Individuals #658, #478, #768 receive feedings while in recliners. | |
| 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. | Per document review and interview with the Habilitation Director, all direct care professional staff participate in a foundational class during orientation; however, this course was not renewed or recertified on an annual basis. Additionally, the training is presented in sections (i.e., nutrition as one class and positioning as another class) and does not fully address the concept of physical and nutritional management.<br><br>Person-specific training was provided to staff who routinely work at a specific home; however, there was no process in place to provide this additional training should a home have to utilize floating staff or pull DCPs from another home. It is essential that PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff that have successfully completed competency-based training specific to the individual. | |
| 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. | Monitoring was an area which was lacking. There is currently no process in place that clearly defines who will conduct monitoring, the frequency in which the monitoring will be completed and how the data from the monitoring will help shape future services.<br><br>In addition to the lack of a clear monitoring system, a process does not exist that includes validation checks to ensure accuracy of monitoring.<br><br>Monitoring data collected was reviewed and was found to not be indicative of the issues seen by the monitoring team. See O-4 for additional information. | |
| 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. | Monitoring focuses primarily on whether or not equipment is available and staff are implementing the strategies as listed in the PNMP and dining plan. The effectiveness of the plan was not clearly monitored. The determination of whether a plan is effective or not requires clinical decision making and therefore should only be completed by individuals who have expanded experience with physical and nutritional issues. | |
| 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 | A system does not currently exist that ensures individuals who receive enteral nourishment receive annual assessments that address the medical necessity of the enteral feedings as well as potential pathways to return to oral intake.<br><br>Comprehensive evaluation should be utilized to determine their feasibility of returning to oral intake and to allow for comparison of swallow function from year to year. Identified in these evaluations should also be strategies that have been developed to | |

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| | use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding. | transition an individual to oral intake, if appropriate. | |

**Recommendations:**

1. DSSLC should review their entire PNM system to ensure that the PNM team is a therapy-driven collaborative team that focuses on proactive preventative care. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. Therefore, DSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk. Additionally, the level of risk should be openly shared with staff and used to help drive and shape future services.
2. The HST and NMT currently meet separately although they both cover and share much of the same information. Due to this redundancy and lack of a clear PNM team, it is recommended that DSSLC investigate ways to further integrate their function and develop a single team that covers all aspects of physical and nutritional management
3. Assessments should be reviewed and revised so that all aspects of physical and nutritional management are addressed. This includes assessing oral care, medication administration and positioning for these activities as well as positioning for improved GERD management and stomach emptying. DSSLC should also focus on improving the use of measurable terminology and consistency between assessments and clinicians.
4. PNMPs should be revised to contain the strategies identified via the assessments and eliminate vague terminology with regards to the listed strategies in an effort to increase consistency of implementation by staff. Included in the PNMP and PNM process should be oral care, medication administration and signs and symptoms associated with aspiration that mandate nursing referral, assessment (vitals, lung sounds, and oxygen saturation) and PNMP referral. Training as well as reporting and recording of all incidents should be part of developing this process.
5. A process should be developed that provides clear guidelines regarding the timeliness in which new interventions or change in status information is integrated into all support plans and ensures these timelines are met so that changes in status (such as hospitalization for aspiration pneumonia) are responded to on a timely basis and are integrated into PSPs. Currently, this process is informal which results in inconsistent integration.
6. A training system should be considered that ensures all staff are regularly trained on all aspects of physical and nutritional management. The training curriculum needs to be expanded with specific learning objectives and competencies to provided foundational knowledge and skills related to: mealtime position and alignment, diet texture and consistency, presentation techniques to enhance nutritional intake and hydration, care and use of adaptive equipment, aspiration and choking precautions, purpose of a swallow study, strategies to support independence during PNM activities, presentation and alignment to support safety during oral care, bathing, and medication administration. This should include orientation training as well as regular updates.
7. Care should also be taken to ensure that all staff are provided with individualized competency based training prior to working with an individual who is considered to be at an increased risk.
8. A monitoring system should be implemented that focuses on plan effectiveness rather than just presence and implementation. All staff conducting the monitoring for plan effectiveness should have the clinical knowledge to make such determinations and those monitoring for implementation and presence should have additional training as well to ensure consistency and accuracy. The system should be data-driven to allow proper analysis and tracking of trends.
9. Comprehensive evaluation should be utilized to determine their feasibility of returning to oral intake and to allow for comparison of swallow function from year to year. Identified in these evaluations should also be strategies that have been developed to transition an individual to oral intake, if appropriate.
10. DSSLC should consider reviewing the policy towards providing enteral nourishment to individuals who are in recliners. Recliners do not provide

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| an adequate level of support to maintain a position over an extended period of time thus increasing the likelihood that individuals will fall out of appropriate positioning while receiving their feedings. |

| SECTION P: Physical and Occupational Therapy | |
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| Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>• Record Reviews of Individuals #703, #11, #633, #163, #416, #768, #766, #536, #552, #499, #496, #453, #672, #19, #392, #589, #524, #118, #245, #449, #327, #364, #44, #574, #240,#1, #248, #326, #329, #776, and #509.<br>• Review of requested tour documents including but not limited to:<br>o Occupational and Physical Therapy assessments<br>o PNMP clinic minutes 3/2009 to 3/2010<br>o Occupational and physical therapy policies and processes<br>o List of individuals who are considered to be at risk of Falls and skin breakdown<br>o Adaptive equipment spreadsheets<br>o Wheelchair assessments<br>• Reviewed the applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management<br><br>**People Interviewed:**<br>1. Donna Groves OTR, Director of Habilitation Services<br>2. Joy Sibley SLP, Director of Communication Therapy<br>3. Meeting with RN Case Managers<br>4. Dr John Beall RN, Chief Nurse Executive<br>5. Sherry Courtney RN, Operations Nurse<br>6. Sibylle Graviett, RN, RN Case Manager Leader<br><br>**Meetings Attended/Observations:**<br>• Observations of 503b, 522b, 512b, 513b, 502c, 502d, 514b, 513a, 522a, 522c, 522d living areas and dining rooms.<br>• Attended HST quarterly 3/30/2010<br>• NMT meeting 3/31/2010<br>• RN Case Managers Meeting 3/30/2010<br>• Positive Behavior Support Committee 4/1/2010<br>• PNMP clinic 3/31/2010 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Currently, DSSLC has eight full time Occupational Therapists, seven Occupational Therapy Assistants, and five full time Physical Therapists. DSSLC has listed three full time PT positions but as of this review, the positions have not been filled.<br><br>Habilitation Therapies have and continue to provide assessments; however, clear expectations regarding |

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| | the frequency and depth of the assessments was missing.<br><br>While the assessments contained information relevant to areas of functional mobility and adaptive positioning equipment, they were lacking in detail contained in HCG VII. Missing information includes behavioral issues and how they impact PNM, oral management and positioning during medication administration and oral hygiene as well as positioning for GERD management and stomach emptying. The rationale and justification behind a therapists' recommendation was also lacking in detail and did not provide a clear picture of how the interventions would benefit the individual.<br><br>Individuals who have plans in place (positioning, alternative positioning, and/or mealtime) are not consistently provided with supports, and there is not an effective monitoring system in place that provides reliable data and tracking. |

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| P1 | By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner. | All individuals at DSSLC have been provided with an assessment; however, the assessments are lacking in detail as it relates to providing the justification of recommended interventions and how these interventions are meaningful to the individual and improve their overall level of functioning. Areas that are lacking include the sections covering swallowing function, safe dining, and oral management and positioning during medication administration and oral hygiene as well as positioning for GERD management and stomach emptying. The Oral Motor section functions primarily as a general observation rather than a full swallowing assessment. Additionally, the assessments are narrative in format resulting in a high level of variability between assessments and between clinicians.<br><br>Individuals who experience significant changes or physical health events are not consistently reassessed to determine if modification of services is needed. Refer to provision O.2 for additional information.<br><br>The OT/PT assessments have been integrated into a single assessment; however, upon review; the assessments are not consistently completed in tandem and at times were only completed by the OT. | |
| 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 | While the PT/OT assessments have been completed, they are not adequately integrated into the PSP. Upon review of the PSP, the assessments are referenced but are not integrated as part of the summary of the individual, and the PSP did not clearly provide information regarding the individual's strengths and weaknesses and how the proposed interventions provided in the PT/OT assessment will benefit the individuals in living a more independent and functional life.<br><br>Individuals are not consistently provided with alternate positions identified per their | |

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| | 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. | positioning schedule nor are they consistently positioned appropriately in their wheelchairs. Refer to provision O.4 for additional information. | |
| 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. | DCPs were provided with initial training, but there is not a clear process for ensuring ongoing education. Refer to provision O.5 for details | |
| 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. | There was not a clear policy or process in place that clearly defined frequency or depth of the monitoring process nor did it provide direction regarding its implementation and action steps to take should issues be noted. Refer to provision O.7. | |

**Recommendations:**

1. The current assessment format needs to be reviewed to determine if the current assessment format is sufficiently comprehensive to identify the needs of the individuals at DSSLC. Special care should be given to the areas of oral care, medication administration and oral motor as well to improving overall detail.
2. Habilitation Therapy information should be integrated into the PSP and not just merely referenced. Justifications for the interventions and how these interventions play a role in improving the quality of life as well as how they are integrated into other areas of living should be included.
3. A training system should be considered that ensures all staff are regularly trained (Refer to SA O recommendation)
4. A monitoring system should be implemented that focuses on plan effectiveness and ensures implementation. Included in the monitoring should be methods to ensure appropriate wheelchair conditioning and positioning. (Refer to SA O recommendation)

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DSSLC Dental/Medical Sedation and Restraint Policy and Procedure, GMGMT-21, Date Revised: 11/05/09<br>2. DSSLC Restraint Log, 07/01/09 through 02/09/10<br>3. DSSLC Oral Health Care for People with Special Needs, Guidelines for Comprehensive Care, Curriculum<br>4. DSSLC Facility Oral Hygiene Levels Reports, September, 09 through February, 2010<br>5. DSSLC Dental Hygiene Training – Shift Overlap Training Curriculum DSSLC Weekly Dental Schedule for 10/01/09 through 03/01/10<br>6. DSSLC Refused Dental Treatment Lists, July, 2009 through March, 2010<br>7. DSSLC Emergency Dental Exams List, July, 2009 through March, 2010<br>8. DSSLC Preventive Dental Care List, July, 2009 through March, 2010<br>9. Partial Records Reviewed for Individuals # 534, #731<br><br>**People Interviewed:**<br>1. Patti Artman, Medical Coordinator<br>2. Rebecca Mariani, Dental Hygienist, Dental Clinic Coordinator<br>3. Pam Foumier, Dental Assistant II<br>4. Cynthia Murrell Dental Hygienist<br>5. David J. Gotban, DMD, Dentist/Dental Anesthesiologist<br>6. Russell W. Reddell, DDS<br>7. Dr. Tai Kim, Medical Specialist II<br>8. Randy Spence, Director of Behavioral Services<br><br>**Meeting Attended/Observations:**<br>Tour of Dental Clinic<br>Tour of Medical Clinic for Individual #731 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br><br>DSSLC had an onsite dental clinic that was well staffed. The dental clinic has a computerized system for scheduling appointments and collecting data. It was unclear how refused and missed appoints were rescheduled or follow-up. Unique to DSSLC's Dental Clinic, they have a wheelchair lift that reclines such that individuals with severe osteoporosis and mobility problems can safely and comfortably be examined and treated without having to be removed from their wheelchair.<br><br>Review of dental records found that there was sufficient information to inform their PSP of the specific condition of the individuals' teeth, necessary dental supports, and interventions. This was best validated |

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| | by cross walking individuals' dental records with their PSPs that reflected their dental plan of care, plus other dental services when indicated.<br><br>Review of dental records and PSPs indicated they failed to include specific recommendations for desensitization for individuals identified as needing some form of dental sedation. According to the dental staff interviewed, if an individual refused services three times, the request for a desensitization program was sent to the Human Rights committee and to their guardian for consent. Also, the dental clerical staff e-mailed the need for a desensitization program to the individual's psychologist and QMRP. When asked how long this process took for the desensitization program to be developed and implemented, the staff stated that the process was not very successful. This issue was further discussed with the Director for Behavioral Services; who agreed that the process of developing and implementing desensitization programs was not very successful. This was an issue the facility was working to improve.<br><br>The facility does have safeguards in place to ensure the health and safety of individuals receiving pre-treatment and IV sedation. A dental anesthesiologist provides IV sedation and constantly monitors the individual while sedated. The dental anesthesiologist was Advanced Cardiac Life Support (ACLS) certified and supplies his own emergency equipment. The dental clinic staff reported that two nurses at the facility are also ACLS certified. After the IV sedated individuals' dental procedures were completed they were taken to the Infirmary for post-sedation monitoring. Before returning to their home the assigned physician assessed their health status to ensure all systems were stable and they were totally recovered.<br><br>According to the dental hygienist, the nursing staff was trained in the use of suction toothbrushes for individuals at risk for aspiration. Further, they had begun oral hygiene training called "shift-overlap training" with the direct care professionals (DCP). This training catches the off-going and on-coming staffs. Validation of this training was maintained in the facility's Competency, Training, and Development (CTD) database. |

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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 | DSSLC provides onsite dental services. The Dental Clinic was staffed with three part-time dentists, one of whom is a dental anesthesiologist, two dental hygienists, contracted dentists, and a dental surgeon who comes in on an as-needed basis, and clerical support. Dental services report to the facility's medical director. The Dental Clinic maintains a computerized appointment scheduling system. Although, the clinic was able to produce monthly lists of individuals who received preventive care and those who refused dental treatment, it was unclear how their system tracked appointments that were rescheduled or how individuals who refused dental treatments were tracked for follow-up. Review of the records failed to provide clear information regarding individuals who refused or who missed appointments flow back to their respective qualified mental retardation professional (QMRP). The clinic needs to develop and implement a formalized tracking | |

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| | guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards. | system to ensure that refused and/or missed dental appointments are rescheduled and/or followed-up as appropriate.<br><br>Review of the Emergency Dental Exams List, July, 2009 thorough March 2010, listed individuals who had received emergency dental exams.,as was demonstrated for individuals #177, #527, #259, #102, #110, #149, #732, #53, #35, and #702. | |
| 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. | Review of individuals' #s 534, #568, #409, #496, #419, and #569 dental records found that there was sufficient information to inform their PSP of the specific condition of the individuals' teeth, necessary dental supports, and interventions. This was best validated by cross walking these individuals' dental records with their PSPs that reflected their dental plan of care, plus other dental services when indicated.<br><br>The dental examination records only had a "yes" or "no" indicator marked regarding the individual's desensitization session. The records failed to include specific recommendations for desensitization. According to the dental staff interviewed, if an individual refused services three times, the request for a desensitization program was sent to the Human Rights committee and to their guardian for consent. Also, the dental clerical staff e-mailed the need for a desensitization program to the individual's psychologist and QMRP. When asked how long this process took for the desensitization program to be developed and implemented, the staff stated that the process was not very successful. This issue was further discussed with the Director for Behavioral Services; who agreed that the process of developing and implementing desensitization programs was not very successful. This was an issue the facility was working to improve.<br><br>In an effort to gain insight into the percentage of individuals who might be receiving intravenous (IV) sedation, the Weekly Appointment Schedule for 10/01/09 through 03/01/10 was reviewed because it indicated individuals who were scheduled for IV sedation. There were 807 appointments scheduled for which 86 or 10.6% were marked to receive IV sedation. Of those scheduled, a few individuals were scheduled twice for IV Sedation; the 86 appointments involved 77 separate individuals who might have benefited from desensitization programs. Those individuals included: #614, #487,#591, #664, #619, #773, #527, #718, #658,, #508, #611, #733, #632, #37, #270, #189, #610, #181, #746, #244, #572, #52, #244, #287, #80, #2, #530, #370, #400, #188, #171, #670, #621, #265, #192, #585, #133, #510, #752, #59, #237, #45, #259, #395, #697, #201, #80, #178, #33, #452, #661, #408, #65, #232, #242, #130, #258, #568, #738, #153, #311, #485, #762, #793, #413, #15, #553, #425, #221, #55, #701, #795, #660, #716, #545, #67, and #396. The individuals listed above represented six months of appointments, there were probably other individuals not included who might benefit | |

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| | | from a desensitization program. Every effort needs to be made to reduce or eliminate the use of all forms of sedation. When using various forms of sedation for dental services the facility's and state needs to consider following the American Society of Anesthesiologist (ASA) Physical Status Classification system. This link is found at http://saiddent.org/modules/13_modules5.pdf. The PSTs and PBSTs need to re-assess individuals for the development and implementation of desensitization programs.<br><br>The only policy available for review was the Dental/Medical Sedation and Restraint, Policy and Procedure, CMGMT-21. Reportedly dental policies and procedures were in process at both the state and facility level. The facility needs to develop and implement local dental policies and procedures in alignment with the Settlement Agreement (SA) and Health Care Guidelines (HCG).<br><br>Review of the facility's Restraint Log listed medical use, failing to specify which restraints were used for dental. Therefore, it was not possible to discern dental restraint use. In an effort to determine restraint use for dental services, the facility should differentiate between medical and dental use.<br><br>The facility does have safeguards in place to ensure the health and safety of individuals receiving pre-treatment and IV sedation. A dental anesthesiologist provides IV sedation and constantly monitors the individual while sedated. The dental anesthesiologist was Advanced Cardiac Life Support (ACLS) certified and supplies his own emergency equipment. The dental clinic staff reported that two nurses at the facility are also ACLS certified. After the IV sedated individuals dental procedures were completed they were taken to the Infirmary for post-sedation monitoring. Before returning to their home the assigned physician assessed their health status to ensure all systems were stable and they were totally recovered. This was validated through discussion with Dr. Kim and review of individuals' #s 731 and #419 records documenting their care while under IV sedation, and follow-up assessments in the medical clinic by a physician.<br><br>Review of the dental clinic's Facility Oral Hygiene Levels, compiled monthly indicated the overall hygiene level analysis of all the individuals seen in the dental clinic by percentage of those who had good oral hygiene, fair oral hygiene, and poor oral hygiene. A detailed individual unit report was sent to each unit director. It could not be discerned how this information was used in planning for oral hygiene care. This issue will be followed-up on the next tour.<br><br>According to the dental hygienist, the nursing staff was trained in the use of suction toothbrushes for individuals at risk for aspiration. Further, they had begun oral hygiene training called "shift-overlap training" with the direct care professionals (DCP). This | |

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| | | training catches the off-going and on-coming staffs. Validation of this training was maintained in the facility's Competency, Training, and Development (CTD) database.<br><br>Unique to DSSLC's Dental Clinic, they have a wheelchair lift that reclines such that individuals with severe osteoporosis and mobility problems can be safely and comfortable be examined and treated without having to be removed from their wheelchair. | |

**Recommendations:**

1. The facility's Dental department needs to develop and implement a formalized tracking system to ensure that refused and/or missing dental appointments are followed-up as appropriate.
2. When using various forms of sedation for dental services the facility and the state need to consider following the American Society of Anesthesiologist (ASA) Physical Status Classification system. This link is found at http://saiddent.org/modules/13_modules5.pdf.
3. The facility's PSTs and PBSTs need to re-assess individuals for the development and implementation of desensitization programs. Every effort needs to be made to reduce or eliminate the use of all forms of sedation and restraints.
4. The facility's Dental department needs to differentiate between restraint used for medical and dental use.
5. The facility needs to develop and implement local dental policies and procedures in alignment with the SA and HCG.

| SECTION R: Communication | |
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| Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below: | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>• Record Reviews of Individuals #703, #11, #633, #163, #416, #768, #766, #536, #552, #499, #496, #453, #672, #19, #392, #589, #524, #118, #245, #449, #327, #364, #44, #574, #240,#1, #248, #326, #329, #776, and #509.<br>• Review of requested tour documents including but not limited to:<br>o AAC and Speech assessments<br>o Monitoring tools<br>o AAC spreadsheet and order log<br>o Speech and Language policies and processes<br><br>**People Interviewed:**<br>1. Donna Groves OTR, Director of Habilitation Services<br>2. Joy Sibley SLP, Director of Communication Therapy<br>3. Meeting with RN Case Managers<br>4. Dr John Beall RN, Chief Nurse Executive<br>5. Sherry Courtney RN, Operations Nurse<br>6. Sibylle Graviett, RN, RN Case Manager Leader<br><br>**Meetings Attended/Observations:**<br>• Observations of 503b, 522b, 512b, 513b, 502c, 502d, 514b, 513a, 522a, 522c, 522d living areas and dining rooms.<br>• Attended HST quarterly 3/30/2010<br>• NMT meeting 3/31/2010<br>• RN Case Managers Meeting 3/30/2010<br>• Positive Behavior Support Committee 4/1/2010<br>• PNMP clinic 3/31/2010 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>The majority of individuals have not been provided with a comprehensive speech and language assessment. As of this review, approximately 100 individuals have been assessed to determine if they would benefit from an assistive communication device.<br><br>DSSLC has only 2.5 Speech positions at this time resulting in difficulty performing assessments in a timely manner and difficulty maintaining an appropriate speech system. Due to the limited number of Speech Therapists, active participation in the team process (participation in meetings, monitoring. and development of goals) is not occurring in a timely and comprehensive manner. Individuals who may require speech services are being overlooked because his/her name is not next on the list to provide an assessment. |

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| R1 | Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. | There are currently 2.5 Speech Pathologists with 1 Speech Technician on staff at DSSLC. This has resulted in a very large caseload of approximately 220 individuals per therapist. Carrying a caseload this large makes it increasingly difficult to provide proactive involvement as most of the clinician's time is spent completing assessments and provides little time for continued supports to be provided by the Speech Pathologist. | |
| R2 | Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions. | The majority of the individuals living at DSSLC have not been provided with comprehensive Speech or AAC assessments. Per interview with the Communication Therapy Director, DSSLC has developed a 5 year plan that will result in all individuals receiving an assessment. As of this review, 100 individuals have received an assessment by the Speech Language Pathologist.<br><br>Many individuals who have been provided with assessments by the SLP and recommended for AAC have not received the needed devices. Per interview with the Director of Communication Therapy, this is often due to ordering issues and delays. For example;<br>• Individual #633's device was ordered on April 25, 2008 but the device was not implemented until October 10, 2008<br>• Individual #499's device was ordered January, 2010, but the device has not arrived as of March 31, 2010<br>• Individual #245's device was ordered January, 2010, but the device has not arrived as of March 31, 2010<br><br>In addition to the delays, there is not a clear process in place to assist the individual in communicating while the device is ordered. Per interview with the Director of Communication Therapies, there should be individualized communication dictionaries available in the "Me" books; however, these were not present on three of three units checked.<br><br>Goals written by the Speech Pathologist (SLP) are not consistently followed and data | |

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| | | acquired regarding the goal is not analyzed by the SLP.<br><br>Per interview with the Habilitation Director and Director of Communication Therapy, there was no clear policy or process that defines the schedule or criteria regarding whether an individual receives a speech update or full assessment. In addition, there was no policy in place that defines the frequency in which such assessments would be provided. | |
| 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. | Results from the speech assessment are only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit are not clearly integrated into the PSP.<br><br>Communication dictionaries are developed by the QMRP with input from the team. This dictionary is to be utilized by staff in an effort to improve interaction and understanding of those individuals who are nonverbal. Observations of the Infirmary, 503b, 522 b and 512b indicated that staff was not knowledgeable of this dictionary or its contents.<br><br>Other than mentioning the device, dictionary and or assessment, the PSP does not contain information regarding how the individual communicates and strategies that staff may utilize to enhance communication.<br><br>There are many AAC devices at the apartments not in working order. For example:<br>• Individual #392's Big Mack was not working due to dead batteries.<br>• Common area AAC devices on 522b and 522c are not functioning.<br>• Common area AAC devices on 522b and 522a are in poor condition and not working properly..<br><br>Individuals' AAC devices are not consistently available for use or are incorrectly placed on wheelchair. For example:<br>• Individual #11 was in bed and his communication device was attached to his chair.<br>• Individuals # 768 and #478 spend approximately half their day positioned in a recliner; however, their devices are adapted only to their wheelchairs and daybeds.<br>• Individual #524's "Big Mack" communication device should be located on the individual's left side by her head. The device was located on her right side by her waist. | |
| R4 | Commencing within six months of the Effective Date hereof and with | DSSLC does have a monitoring form that tracks the presence and working condition of the AAC equipment but this form does not include whether a device is being used or is | |

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| | full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually. | effective in improving the individual's communicative ability. .<br>Monitoring should cover all areas in which the use of the device is applicable (which should be all the time). As mentioned in section O-7, effectiveness of the device may only be determined by a professional with expertise in that related area; therefore, the implementation of the plans should be followed by the Speech Pathologist. Additionally, the results of the monitors are not collected and utilized to drive future speech interventions.<br><br>Per observation and review, the current monitoring process is not effective in maintaining the proper functioning or implementation of AAC devices. See Section R-3 for specifics.<br><br>Per interview with Communication Therapy director, devices are often misplaced or lost resulting in devices often having to be replaced. This results in a delay of providing treatment and devices to others. | |

**Recommendations:**

1. DSSLC and state of Texas should review the caseload and job duties of Habilitation Therapies to ensure that current staffing levels are appropriate to meet the demanding need of physical and nutritional supports.
2. DSSLCC and state of Texas should locate Speech Pathologists as soon as possible so that the needs of the individuals will begin to be met. The Speech language pathologist should be well educated regarding the needs of this population including language and swallowing supports. It is important for all individuals (verbal and nonverbal) be provided with appropriate communications assessments.
3. An increased presence and utilization of communication devices is needed at DSSLC. Individuals who are verbal as well as nonverbal should be provided with comprehensive speech assessments. Communication devices should be present in common areas for use by multiple individuals and staff should be provided with frequent training regarding the benefits of AAC as well as its implementation. Additionally, a monitoring process should be developed to ensure the devices are readily available and working properly. It may be beneficial to develop a log that would be completed on a daily basis by the building coordinator to ensure devices are working properly and are available. If not available, an investigation should be conducted and security notified as this may be an issue of theft.
4. Assessment frequency and depth should be clearly outlined in a policy and followed by the Speech Pathologist. More frequent assessments should be required for those who are receiving services or are in greater need.
5. DSSLC should investigate methods to expedite the ordering process as it relates to the acquisition of AAC devices. DSSLC should also look into temporary alternatives that will help facilitate language while the device is being repaired or ordered.

| **SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs** | |
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| Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below. | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>Documents reviewed for the following individuals: #28, #91, #247, #337, #458, #591, #661, #669, #681, and #799, including the annual PSP, PSP updates, SPOs, PBSPs, 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, and behavioral and functional assessments.<br><br>**People Interviewed:**<br>1. Harvey Stephens, Business Procurement Manager<br>2. Yvonne Kendricks, Rehabilitation Therapy Technician V<br>3. MRAs in American Legion day habilitation program and University of North Texas (UNT) Dish Room<br>4. Frank Padia – Director of Program Coordination<br>5. Randy Spence, MS – Chief Psychologist<br>6. Dora Tillis – Assistant Director of Programs<br>7. Active Treatment Coordinator<br>8. Lifeskills Coordinator<br>9. Recreation Coordinator<br>10. Vocational Training Coordinator<br>11. All Psychology Department staff<br>12. Dr. Lin – Psychiatrist<br>13. Dr. Satpathy - Psychiatrist<br>14. Anita Ezenberger – Building Coordinator (504)<br>15. Shenice Taylor – Building Coordinator (527)<br>16. Two DCPs (507)<br>17. DCP (504)<br>18. DCP (505)<br>19. Rehab Therapist (ICD121)<br>20. Rehab Therapist (ICD128)<br><br>**Meeting Attended/Observations:**<br>1. Tours on 4/1/10 of American Legion day habilitation program (12:30-1 p.m.) and University of North Texas Dish Room (1:15-2 p.m.) with Harvey Stephens and Yvonne Kendricks<br>2. IRT – Eastfield<br>3. Psychiatric Clinic – 504, 522<br>4. PSP – 524 |

| | |
|---|---|
| | 5. Observations of ICD workshops 121 and 128<br>6. Observations of meals, program implementation and leisure activities in residences 504, 505, 507, 509, 513, 514, 515, 522, 524, 527 & 528<br>**7.** Other individuals who were observed at living, recreation, and work sites include #20, #131, #141, #229, #304, #309, #381, #408, #504, #527, and #731. |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor Assessment:**<br>During the initial site visit to DSSLC, an opportunity was provided to observe and document the status of behavior and training services at the facility. Various strengths were noted while conducting these observations. These strengths include the following.<br><br>• The on-campus work sites were well organized, goal oriented and presented a variety of vocational choices to the individuals employed there. As a result, individuals were successful at their chosen tasks and were not observed to rely upon undesired behavior to meet personal needs.<br>• The early stages of supported employment have been initiated. Additional monitoring will be needed in this area, but these first steps are encouraging.<br>• It was frequently apparent that multiple disciplines were integrated into the habilitative process.<br><br>Substantial limitations were also reflected during the site visit. Record reviews, observations and staff interviews reflected a teaching process that lacked components necessary to produce, maintain or strengthen individual skills. Skill assessments lacked the rigor and sophistication to determine the strengths and needs of the individuals living at DSSLC with accuracy or validity. Formal teaching plans did not typically conform to the standards of applied behavior analysis and lacked the components necessary to effectively strengthen behaviors.<br><br>Observations in residences did not often reveal ongoing engagement or teaching. The acquisition and maintenance of behavior requires a formal and systematic approach. In addition, however, there must also be active engagement of the individuals by those who are responsible for teaching. Many staff members appeared to lack the ability to implement teaching programs in a formal and systematic manner. At times this was due to limited resources or personnel. There were also several settings where the resources and personnel were available, but effective teaching was not being implemented. |

| # | Provision | Assessment of Status | Compliance |
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| S1 | Commencing within six months of the Effective Date hereof and with full implementation | The data below reflect a review of the records of 10 individuals regarding assessment of personal skills and abilities. Substantial limitations were noted across the majority of areas requiring assessments. Behavioral and psychology assessments have been discussed in Section K. Psychiatric assessments are subjective. Other skill areas are typically assessed via rating scales or other procedures that lack standardization and sophistication. Due to these limitations, although some training programs may reflect needs identified in skill assessments, it cannot be stated unequivocally that the assessments are accurate or have identified real and | |

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| | 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. | meaningful needs, including skills aimed at overcoming obstacles to movement to community living. As illustrated in Section 4, individuals were often observed to display specific needs, such as appropriate seeking of attention, that were not addressed. Furthermore, activities and materials, when provided to individuals, were not individualized or intended to address specific training needs or objectives.<br><br>Explanation of scores for tables:<br>Rating for each item in a table can be 0 (Not Successful), 1 (Partially Successful) or 2 (Fully Successful).<br>Each table below has a column called Average Score. The Average Score is the average of each sample item's or person's score on that item. The average can be from 0 to 2. A higher average score can show progress has been made meeting that item.<br><br>Each table also has a column for Percentage FS. The Percentage FS is the percentage of the people in the sample group who were rated as 2 (Fully Successful). A higher percentage shows that more people in the sample scored a 2 for that item.<br><br>An item with a higher Average Score can still have a low Percentage FS. This is because the two numbers show things in different ways. By comparing both numbers from site visit to site visit, progress can be measured in two different ways. | |

| | Adequate habilitation training provided to individuals | | Average Score | Percent FS |
|---|---|---|---|---|
| 1 | Skill acquisition plans have been implemented to address needs identified in: | | 1.00 | 0.0% |
| | a. | Psychological assessment (K 5). | 1.50 | 60.0% |
| | b. | Psychiatric assessment. | 0.70 | 0.0% |
| | c. | Language and communication assessment. | 0.30 | 0.0% |
| | d. | PSP. | 0.70 | 0.0% |
| | e. | Other habilitative, adaptive skill or similar assessments. | 1.10 | 10.0% |
| | f. | Medical assessments. | 0.80 | 40.0% |

The data below reflect a review of the records of 10 individuals regarding the structure and content of skill acquisition programs.

| | Adequate habilitation training provided to individuals | | Average Score | Percent FS |
|---|---|---|---|---|
| 2 | Skill acquisition plans include components necessary for learning and skill development. At a minimum, these components include the following. (All items below must be FS for this to be scored FS) | | 0.90 | 0.0% |
| | a. | Graphed data are reviewed monthly or more frequently if needed, such as due to | 0.10 | 0.0% |

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| | | | | use of restraints or changes in risk level. | | | |
| | | | b. | Review is conducted by a BCBA. | 1.10 | 30.0% | |
| | | | c. | Input from direct care staff is solicited and documented. | 0.30 | 0.0% | |
| | | | d. | Modifications to the PBSP reflect data-based decisions. | 0.10 | 0.0% | |
| | | | e. | Criteria for revision are included in the PBSP. | 0.30 | 0.0% | |
| | | | f. | Progress evident, or program modified in timely manner (3 Months). | 0.00 | 0.0% | |
| | | | g. | Review is conducted by a BCBA. | 0.90 | 10.0% | |
| | | | h. | Input from direct care staff is solicited and documented. | 1.10 | 30.0% | |
| | | | i. | Modifications to the PBSP reflect data-based decisions. | 0.20 | 10.0% | |
| | | | j. | Criteria for revision are included in the PBSP. | 0.00 | 0.0% | |
| | | | k. | Progress evident, or program modified in timely manner (3 Months). | 0.00 | 0.0% | |
| | | | l. | Documentation methodology | 0.90 | 0.0% | |

At the time of the site visit, skill acquisition programs seldom included the basic components considered essential to the acquisition and strengthening of behavior. As indicated above, assessments were at best rudimentary. The training programs themselves were typically vague and general, preventing consistent and effective implementation of teaching methodologies. Training sessions as described often included too few trials for learning to take place and lacked consequences likely to enhance the learning process.

Two records revealed revisions to the tools and procedures for task analysis and skill assessment. This is a very positive step towards enhancing the skill acquisition process. Future reviews will be necessary to determine if these revisions are sufficient to improve the quality and outcome of skill acquisitions programs.

| | **Adequate habilitation training provided to individuals** | **Average Score** | **Percent FS** |
|---|---|---|---|
| 3 | Overall, the set of skill acquisition programs promote growth, development, and independence | 0.40 | 0.0% |

Due to the limitations noted in the assessments of skills, the identification of needs and the components of skill acquisition programs, at the time of the site visit it was unlikely that the majority of skill acquisition programs were effectively enhancing the skills and independence of the people living at Denton State Supported Living Center.

| | **Adequate habilitation training provided to individuals** | **Average Score** | **Percent FS** |
|---|---|---|---|
| 4 | A plan is in place to address, monitor, and maintain reasonable levels of individual | 1.00 | 0.0% |

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| | engagement in all settings at the facility, including residences, day programs, and work sites. | | |

Reviews of the records for 10 individuals, as well as observations of those and other individuals in a variety of settings reflected an overall inability to provide reasonable levels of individualized engagement. In several settings, there was a pervasive lack of engagement.

- In residence areas 504, 505, 507, 509, 527, and 528 staff ratios were observed to be no less than 1:3. Nevertheless, there were very few structured activities being conducted and individuals were often sitting in front of the television. Upon inquiry, staff would produce crayons, markers and paper, as well as magazines.
- In apartment 527C, one individual frequently cursed loudly. When a staff member would sit beside this individual and interact this cursing dropped substantially in volume and frequency. Staff did not attempt to use this relationship to minimize the behavior.
- In apartment 504B, staff rarely spoke to the individuals living there unless an individual displayed an undesired behavior. Activities available to individuals were limited to crayons, markers, paper and a Connect Four game.
- In apartment 504B, individuals are observed engaging in minor self-injury and stereotypic behavior staff was not observed to intervene. Upon inquiry, staff reported that they will often provide edibles to individuals engaging in such behavior "to keep them happy."
- Staff in apartment 504B is unable to resolve whether an individual who recently choked on a preferred food is to be restricted from that food.
- Staff in apartment 524C report that no individuals require behavior support. A review of records reflects PBSPs are in place for at least one individual that include instructions for enhancing the level of activity and stimulation.
- Interviews with several active treatment staff revealed little familiarity with the concept or application of active treatment.

The data below reflect a review of the records of 10 individuals regarding application of skill acquisition programs. Based upon these data and the observations noted above, there is little to suggest that the majority of skill acquisition programs or teaching sessions incorporate individual preferences. Furthermore, neither records nor staff interviews revealed any formal preference or reinforcer assessments. Similarly, opportunities for informal development and use of various adaptive skills were seldom made available.

| | Adequate habilitation training provided to individuals | Average Score | Percent FS |
|---|---|---|---|
| 5 | There is an adequate array of skill acquisition programs and work and leisure opportunities to: | 1.00 | 0.0% |
| | a. Incorporate individual preferences; and | 0.60 | 0.0% |

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
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<tr><td></td><td>b</td><td>Support active engagement in the absence of individual skill acquisition plans.</td><td>0.70</td><td>0.0%</td></tr>
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</td><td></td></tr>
<tr><td>S2</td><td>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.</td><td>
The data below reflect a review of the records of 10 individuals regarding annual assessments of needs. As indicated previously in this section, while annual assessments are conducted on an annual basis as part of the PSP process, these assessments lack the rigor and sophistication necessary to be considered valid assessments.
<table>
<tr><th></th><th>Standard psychological assessment procedures</th><th>Average Score</th><th>Percent FS</th></tr>
<tr><td>1</td><td>With regard to living, working and leisure activities, records demonstrate annual assessment of each individual in a minimum of the following areas: (All items below must be FS for this to be scored FS)</td><td>1.00</td><td>0.0%</td></tr>
<tr><td></td><td>a. Preferences</td><td>1.30</td><td>60.0%</td></tr>
<tr><td></td><td>b. Strengths</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>c. Skills</td><td>2.00</td><td>100.0%</td></tr>
<tr><td></td><td>d. Needs</td><td>1.10</td><td>10.0%</td></tr>
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</td><td></td></tr>
<tr><td>S3</td><td>Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:</td><td>The implementation of programs to develop skills is variable. The on-campus work sites were well organized, goal oriented and presented a variety of vocational choices to the individuals employed there. As a result, individuals were successful at their chosen tasks and were not observed to rely upon undesired behavior to meet personal needs. Community sites provide opportunities for vocational and leisure activities. In the residential areas, the monitoring team noted lack of activity and engagement. Programs to teach skills are not well-developed, as indicated in S1 and below. Barriers to community integration are not routinely identified as needs to be addressed.</td><td></td></tr>
<tr><td></td><td>(a) Include interventions,</td><td>The data below reflect a review of the records of 10 individuals regarding implementation of skill acquisition programs.</td><td></td></tr>
</table>

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| | 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 | Both observations and interviews with staff reflect that skill acquisition programs are not implemented consistently or as written. Teaching is often conducted in a haphazard manner in terms of schedule and teaching strategy. Cues, prompts and other elements of effective training are often not offered or are presented in an informal and inconsistent manner. No staff members were observed to be collecting data during the implementation of a skill acquisition program and progress notes often reflect that data are missing. As a result, there is little to suggest that the implementation of skill acquisition programs results in meaningful changes in behavior, independence or the quality of life for individuals living at Denton State Supported Living Center. | |
| | (b) Include to the degree practicable training opportunities in community settings. | Two community sites were visited in the afternoon. One site is the day habilitation program at the community center in the American Legion building, a senior center for the community. Individuals were working on crafts in a separate room. By report of staff, the individuals spend the morning in the same room as the senior center participants and usually engage in similar or joint activities. In the afternoon, the individuals have a schedule of crafts and other activities including going out to activities around town. Individuals were engaged in the planned activities. At the UNT Dish Room, two individuals were engaging in productive work. By report from Harvey Stephens, these individuals are paid at $8.20 per hour. During the visit, numerous UNT employees came into the Dish Room. The manager of the dining area reported that this is common, that the individuals from DSSLC have lunch in the same room as dining staff, and that they are very productive. Two DSSLC MRAs provided job coaching; for the two individuals working that day, this | |

| | | Skill acquisition programs individualized and functional | Average Score | Percent FS |
|---|---|---|---|---|
| 1 | | Skill acquisition programs are targeting needs identified by assessments (K5) | 1.00 | 0.0% |
| 2 | | Implementation of skill acquisition plans is adequate for skill development and learning: | 0.90 | 0.0% |
| | a | Plan method is implemented as written. (All items below must be FS for this to be scored FS) | 1.00 | 0.0% |
| | | As assessed by staff report. | 1.00 | 0.0% |
| | | As assessed by observation. | 1.00 | 0.0% |
| | b. | Plan is implemented according to the specified schedule. | 1.00 | 0.0% |
| | c. | Reinforcement is used appropriately. | 0.10 | 0.0% |
| | d. | Prompting and practice are used appropriately. | 0.30 | 0.0% |
| | e. | Plan is practical and functional in the most integrated setting. | 1.10 | 10.0% |
| | f. | Data are graphed. | 0.00 | 0.0% |
| | g. | The plan is producing meaningful behavior change. | 1.00 | 0.0% |

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| | | seemed to be more supervision than required. Harvey Stephens reported that there is consideration of reducing the amount of supervision now that the individuals have demonstrated work skills and appropriate behavior, and that development of additional sites would allow an experienced MRA to become job coach at a new site. These are excellent examples of use of community opportunities. The assignment of an individual to procure more sites is positive and should lead to expansion of sites, which will be reviewed at the compliance site visit. | |

**Recommendations:**

1. DSSLC should develop and implement a competency-based training curriculum emphasizing the application of applied behavior analysis, to the development of skill enhancement programs. In addition, the facility should implement routine monitoring of skill acquisition programs, as well as the implementation of those programs.

2. DSSLC should develop and implement a competency-based training curriculum for these employees emphasizing the skills necessary in the implementation of training programs. This training should include instruction on the techniques of teaching and documentation, as well as the less technical aspects such as building relationships, providing choice, encouraging motivation and making teaching enjoyable.

3. Effective teaching requires sufficient resources and personnel. DSSLC has added personnel in some settings, but it is not clear that these additional staff is being used to enhance teaching. It is recommended that DSSLC review the availability and utilization of resources and personnel and implement changes that ensure effective teaching.

4. DSSLC should build on and continue to expand the use of opportunities for learning in the community, including vocational, recreational, and daily living skills

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br><br>1. Texas DADS SSLC Policy: Most Integrated Setting Practices 018, 10/30/09, and six attachments<br>2. List of alleged offenders committed to the Facility<br>3. List of individuals placed in the community from 7/1/09-3/30/10<br>4. List of individuals referred for community placement<br>5. List of individuals requesting community placement<br>6. List of individuals assessed for placement<br>7. List of alleged offenders residing at the Facility<br>8. PSPs for 30 individuals: Individuals # 26, # 89, #95, #127, #133, #134, #163, #213, #221, #248, #272, #275, #276, #297, #350, #367, #406, #430, #495, #497, #563, #594, #606, #155, #645, # 685, #686, #689, #758, #760<br>9. Community Living Discharge Plans (CLDP) for 5 individuals: Individuals #354, #400, #422, #437, #596<br>10. Community Living Options Information Process (CLOIP) Worksheets for 11 individuals: Individuals #81, #95, #429, #594, #616, #645, #678, #685, #713, #720, #759<br>11. Post Move Monitoring Checklists for four Individuals: Individuals # 400, #422, #437, #596<br>12. Permanency Planning Tracking System Sheets for September 2009, October 2009, December 2009 and March 2010<br>13. Permanency Planning Documents for four individuals: Individuals #127, #229, #297, #482<br>14. Position Descriptions for Admissions and Transitions Coordinator, QMRP-Social Worker and Clinical Social Worker<br>15. List of MRA Discharge Planning Training<br>16. Self-Advocacy Meeting Flyer, Meeting Minutes and Sign-In Sheet dated 9/1/09<br>17. Provider Fair Sign in Sheets for Staff, Individuals and Family dated 2009<br>18. QMRP Training Summaries and Sign-In Sheets<br>19. QMRP Training Outline for QMRP Training For Referral For Alternative Residential Placement held December, 2009<br>20. QMRP Meeting Agenda, 4/2/10<br>21. List of Community Tour Requests provided by Denton County MHMR Center (Contract Mental Retardation Authority), undated<br>22. List of Individuals Touring Homes as tracked by the Contract Mental Retardation Authority (MRA)from September, 2009-February, 2010<br>23. List of DSSLC staff who have made tours of community programs from February, 2009-March 12, 2010<br>24. CLOIP Presentation materials, including Publication 257, Community Living Options Information Process for Legally Authorized Representatives of Residents in State Supported Living Centers, Publication 256, Community Living Options Information Process and Denton County MHMR Center |

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| | Brochure on Community Living Options Information Process<br>25. Community Placement Report, dated 7/1/2009 - 1/31/2010<br>26. PowerPoint presentation entitled Texas Community System provided for DADS scan call on 3/11/10<br>27. Follow-up with Settlement Agreement Monitors document, undated<br><br>**People Interviewed:**<br>1. Frank Padia, Director of Program Coordination (DPC)<br>2. Andy Maher, Director of Consumer and Family Relations (CFR)<br>3. Charlene Cummins, QMRP/Social Worker (Post Move Monitor)<br>4. Judy Roy, Contract MRA CLOIP Supervisor<br>5. CLOIP Service Coordinator<br>6. Parent/LAR of Individual #250<br>7. Rebecca Wilkins, Director of Quality Assurance<br>8. Lori Powell, Settlement Agreement Coordinator<br><br>**Meeting Attended/Observations:**<br>1. PSPs for three individuals: Individuals #87, #138, #673<br>2. CLOIP interview for Individual # 686<br>3. Joint meeting of CFR/Contract MRA staff<br>4. Phone participation in a CLDP for an individual living at Brenham State Supported Living Center (BSSLC) transitioning to a community placement in the Denton region<br>5. Post Move -Monitoring Visits for 3 individuals: Individual #400, Individual #422, Individual #437<br>6. Self-Advocacy Meeting<br>7. QMRP Meeting<br>8. Scan Call with DADS on 3/11/10 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br><br>Denton State Supported Living Center (DSSLC) has reported only eleven individuals moving to the community since July, 2009, and one of those returned within a week. This rate, approximately 1.8% of its population, is on the low end of other SSLCs that have a census of over 400.<br><br>The Facility does have a number of promising elements in place for a comprehensive approach to planning and facilitating transition and discharge to the community, most notably several enthusiastic and creative individuals in key management positions. QMRPs and PSTs have received some training and there has been a noticeable change in the community living content of the PSPs over the past year. The PSTs have expanded the breadth of supports and services an individual may need in expanded community living setting, but there is still considerable focus on the supports and services the person currently receives at the Facility, with less attention to how to incorporate those things that have been identified as "what's most important" to the person. There remains substantial inconsistency in how PSTs identify specific barriers, and very few specific action plans related to those barriers. State and Facility policy do not yet provide |

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| | additional guidance to teams as to the types of obstacles that might be identified nor discuss the teams' role in resolving those barriers.<br><br>Much more training in the fundamentals of person-directed planning and in the implementation of the Settlement Agreement requirements is needed, and the Facility has some in the planning stages.<br><br>The Facility has many good ideas for creating awareness of community living options. Many of these are in the idea phase. It will be important for all of these ideas and strategies to be coordinated in a comprehensive plan. Fortunately, DSSLC and the Contract MRA appeared to have formed a close working relationship. CFR staff and Contract MRA staff interact regularly on an informal basis, hold regular joint meetings and are already working together to design and implement some innovative approaches<br><br>There remains a good deal of work to be done to build the community system of supports and services through the identification of supports and services that individuals living at DSSLC will need to make community living safe and attractive to individuals and LARs, and to ensure those are available and being provided. The CLDP and Post-Move Monitoring processes are in place, but will need to be refined to ensure successful moves. |

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| **T1** | **Planning for Movement, Transition, and Discharge** | | |
| T1a | Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into | In order to encourage individuals to move to the most integrated settings, the State and the Facility must undertake many activities related to planning or movement, transition and discharge as are discussed throughout this section. One of those must be to ensure the community can provide choices of environment that are acceptable to the individuals and LARs who are being encouraged and that can provide the supports identified in the community living discharge plan so that provisions T1C and T1E can be met. This could not be confirmed during these limited baseline visit observations, at least in the area of day programs and opportunities for meaningful work. Those observed in the community settings seemed to offer less in the way of work, paid employment and even day activity than those observed at the Facility. One private day habilitation program observed during a Post-Move Monitoring visit had an activity schedule posted that listed bowling as the daily activity for every day of the month except for a handful which listed a trip to the zoo. When the provider was questioned as to how this schedule was determined, she replied that it was consumer choice. One of the primary advantages of community living should be access to many and diverse recreational options, and individuals should be provided with opportunities to experience and learn about them so they can make choices. In addition to the lack of variety in the activity schedule, there was little structured activity at the day habilitation program site itself during the time the monitoring team was there. | |

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| | account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. | At a second private provider day program, one individual who had transitioned from DSSLC was not engaged in any meaningful activity. He was observed to be sitting at a table with no activity materials of any kind, nor was he engaged in any interaction over a twenty minute period other than to be assisted to the restroom. It was reported by the residential provider that it was planning to stop using this second day habilitation provider within the next week or so and start its own day habilitation program. The time frame for beginning this new program was uncertain, so it was unclear how long the individuals might be without day habilitation services.<br><br>No type of work-related activity was seen at either of the day habilitation programs visited. It was reported that only one sheltered workshop was available in the Denton area, but this was not confirmed during this visit. It was also reported that an individual from DSSLC who had a supported work position in the community while living at the Facility was required to relinquish it when he transitioned to a residential placement in the community. It is recommended that the Facility, DADS and the appropriate MRAs examine the community living options in the DSSLC catchment area to ensure that needed supports and services are available to meet the needs of the individuals considering moving to the community, particularly, but not limited to, day programs and employment opportunities. | |
| 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: | In response to a request for Facility policies, procedures and/or other documents related to assessment of individuals for community placement, the development of individual plans, and individual transition and discharge, DSSLC reported that it only has the state-level policy, Texas DADS SSLC Policy 018: Most Integrated Setting Practices. No policies and procedures have been adopted or otherwise promulgated to further describe the Facility-specific practices required to implement the provisions of the state-level policy. | |
| | 1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the | The monitoring team observed three PSPs and completed a record review of a sample of 30 additional PSPs to assess certain key indicators related to the identification of the protections, supports and services that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on an individual's needs, the identification of obstacles to placement and the identification of strategies to address those obstacles.<br><br>Although each PST reviewed began with an identification of what is most important to the person, it was rare for these to be carried over to the description of an optimal living | |

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| | 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. | vision. The PST did identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation if the person were to move to a more integrated appropriate setting. Across the board, these protections, services and supports appeared to be individualized according to the assessed needs of each individual, but those things identified by the team as important to the person were not used to form the foundation of what a community living option needed to offer to meet the needs of the individual. They tended instead to simply mirror those protections, services, and supports being provided by the Facility, suggesting that teams may benefit from some additional training about opportunities that may be available in home and community based services beyond those available in a large congregate setting This should lead to increased skill of PSTs in how to envision a living option that might make those things that are most important to the person more available. For example, in the PSPs reviewed, shopping at the mall and eating at restaurants were frequently identified as things that were most important to individuals, but the envisioned setting rarely spoke to how often such activities should take place or the supports someone would need, such as transportation to the mall, or a staff person who would facilitate the opportunity to eat at various restaurants at least once or twice a week. The point is that if these activities really represent what is "most important" in terms of lifestyle to individuals, then those things must have a primary consideration as a community living vision is developed. Supports and services that ensure health and safety are not at all unimportant, or even secondary, but they must share a prominent place in the development of any plan with the individual's quality of life desires.<br><br>There has been a suggestion that the PSP meeting be re-structured to have the Community Living Options discussion immediately follow the introductory discussion of what's important to the person, for the purpose of having this vision of an optimal living situation, wherever that may be, drive the development of the rest of the plan. This might also assist the PST to connect those things that are important to the person to the design of the vision.<br><br>PSTs seemed to be very inconsistent in the identification of major obstacles to the individual's movement to the most integrated setting and the identification and implementation of strategies intended to overcome such obstacles. In the 30 PSPs reviewed, 23 had no action plans related to obstacles to community placement, even though 21 of these recommended the individual remain at the Facility. Of the remaining two, one had no recommendation and one did refer for community placement.<br><br>DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices describes, in Section V. Procedures for Identification of Obstacles to Movement to a More Integrated Setting, and assigns responsibility to the QMRP for completing the prescribed form, Identified Obstacles to Individual's Movement. The Policy does not | |

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| | | provide additional guidance to teams as to the types of obstacles that might be identified nor discuss the teams' role in resolving those barriers. Although a segment of the QMRP Training For Referral For Alternative Residential Placement was devoted to the identification of obstacles and the strategies to address them, the outline simply provided the language from Texas DADS SSLC Policy: Most Integrated Setting Practices:<br><br>"You are also required to complete the identified obstacles form. This form lists all of the identified obstacles that prevent the individual from transitioning to the community. The policy states:<br><br>A. The QMRP will be responsible for completing the Identified Obstacles to Individual's Movement form at all living options discussions. (See Exhibit D)<br>B. Once completed, the QMRP will submit the Identified Obstacles to Individual's Movement form to the State Center's Quality Enhancement Department."<br><br>Much additional guidance and training is needed to support the ability of the QMRPs and PSTs to identify barriers and the identification and implementation of strategies intended to overcome obstacles. The role of the individual's QMRP is central to the entire process. The Director of Program Coordination takes a lead responsibility for the training of the QMRPs. Training has been provided in the planning, transition and discharge requirements of the Settlement Agreement and Texas DADS SSLC Policy: Most Integrated Setting Practices 018. According to the document reviewed, the training was intended to provide information regarding the process for initiation, monitoring and closing referrals for alternative placement and to teach/retrain QMRPS on the process for alternative placements. Specific items covered were:<br><br>• What documents are required to open a referral for alternative placement.<br>• All personnel required to attend any meeting where alternative placement is discussed.<br>• How to complete a request slip to open a referral and whom the request is forwarded to in the CFR department.<br>• All submission and completion timelines required for alternative placement.<br>• Will understand all additional documentation required to be provided the receiving community provider or unit.<br>• Time limitations for referrals and how to monitor progress of referral to increase potential for successful placement.<br>• How to identify and address all potential barriers to successful alternative placement.<br>• Acceptable reasons for consideration by the PST to close a referral.<br>• Requirements for immediately opening a referral if a potential safety concern is identified by PST. | |

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| | | • All actions required to protect the safety and well being of an individual determined to be at potential risk for harm by others.<br>• Persons to contact to overcome any potential barriers, which may prevent the individual from being moved to a safer environment.<br>• How to document need for action to promote safety to address potential objections for alternative placement by guardian/LAR<br>• All documentation to show evidence of QMRP monitoring the progress of referral to ensure timely closure of a successful referral for alternative placement.<br>• Review and discuss example of all documentation to demonstrate competency in relation to following and monitoring referral process.<br><br>Upon completion of the training, the QMRPs were to complete a written demonstration of competency and understanding of the information discussed, but this documentation was not reviewed during the baseline visit.<br><br>The Director of Program Coordination stated that he is in the process of completely revising the QMRP Manual to incorporate many of these issues. No portion of it was available for review at the time of the site visit. The monitoring team looks forward to the opportunity to review the Manual at the next visit.<br><br>During the QMRP meeting on 4/2/10, the Director of Program Coordination announced that there would be a training and monitoring initiative in the weeks following the site visit, to include individual Unit trainings, monitoring of PSP/PFW/PST meetings and immediate debriefing sessions to review positives and areas of improvement needed for the PSTs. This type of ongoing, routine training and immediate feedback is needed to make the transition to true person-directed planning and enhance the capacity of the PSTs to implement the requirements of the Settlement Agreement.<br><br>It is also recommended that the QMRPs and PSTs receive additional training in the fundamentals of person-directed planning. One strategy would be to explore some of the person-centered planning models that are designed to put the person, and what is important to the person, really at the center of the process. Examples would include Personal Futures Planning, designed by Beth Mount and Essential Lifestyles Planning, designed by Michael Smull.<br><br>The Facility does not yet have a policy and procedure or consistent system for monitoring the PSP process as it is implemented, although some elements are in place. There are program monitor staff from the Quality Assurance Department who are assigned to review a sample of PSPs for the presence of essential components, although the data are sparse and not necessarily meaningful at this point. The Director of Program Coordination reported that he monitors PSP meetings and provides follow-up training and feedback to the QMRPs, and has plans in place to do much more, as described above. The Post-Move Monitor also has responsibility assigned to monitor PSPs for quality, but | |

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| | | her current workload has not yet allowed for this to occur. The Director of Quality Assurance and the Settlement Agreement Coordinator both reported that the Quality Enhancement plan provided as a part of the document request had been scuttled in the week previous to the site visit. According to the Director of Quality Assurance, a new plan would be developed pending the results of the monitoring team's visit. The Facility will need to evaluate, and incorporate into Facility policy, comprehensive quality assurance procedures for transition and discharge, including specifically the 10% monthly random sample as required by DADS Policy 018 on Most Integrated Setting Practices, but also a methodology that addresses its own quality philosophy, concerns and needs. | |
| | 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. | The monitoring team reviewed documents related to education and awareness activities; interviewed the Director of CFR, the CLOIP Supervisor from the Contract MRA, and the Director of Program Coordination; attended a joint CFR/Contract MRA meeting, observed an annual CLOIP meeting, and reviewed 11 CLOIP Worksheets.<br><br>CLOIP interviews and worksheets are completed for each annual PSP, unless the LAR requests the CLOIP staff not speak with the individual. The monitoring team reviewed 11 CLOIP Worksheets that have been completed since 12/09. In each instance, it was documented that the individual had not visited any community living options, nor had any of the LARs.<br><br>The CLOIP interview attended by the monitoring team was well prepared for by the Contract MRA CLOIP staff. A variety of materials were used, including some with pictures representing community settings. The CLOIP staff reviewed the individual's record and spoke with the QMRP and assigned staff ahead of time. The interview took place in the individual's bedroom, in a quiet environment, and the individual was accompanied by familiar staff. The CLOIP staff interacted appropriately with the individual and spoke to her in terms she was most likely to understand, although there was little evidence the individual comprehended the purpose of the meeting. CLOIP staff also solicited information from the QMRP and familiar staff who accompanied the individual.<br><br>In interviews with the CLOIP Supervisor and the CLOIP staff, both stated that their interactions with most individuals at DSSLC and their families are limited to the annual interview and family contact. They both stated that they feel they are beginning to become more familiar to, and perhaps more trusted by, individuals and families as they are now beginning their third year of the CLOIP process.<br><br>CLOIP tours of community homes and programs are being arranged through the Contract MRA. Both the Director of CFR and the CLOIP Supervisor acknowledged that the volume | |

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| | | of tour opportunities available for staff and individuals has been low. A review of the CLOIP tours scheduled for September, 2009-Februrary, 2010 indicated that a total of 11 tour opportunities were scheduled. Of these, four were cancelled. During that same time period, the Contract MRA documented only 17 individuals making community tours, while list of Community Tour requests, dated 3/30/10 and maintained by the Contract MRA, documented 69 individuals had made such a request. Four of those referrals had been rescinded, but this would still indicate a number of individuals requesting tours who had not yet had the opportunity.<br><br>The Facility also provided a list of 26 DSSLC staff who have toured community programs over a 12 month period from 2/30/09-3/12/10. Twenty-three of those have taken place since September, 2009. Facility staff play a critical role in communication with individuals, LARs, and families as the familiar and trusted contacts, and need to have awareness of the realities of community living options. During an interview with the Director of Program Coordination, he stated that the QMRPs are the primary contact with DSSLC families, yet only five QMRPs have made such tours, according to the documentation.<br><br>DADS and DSSLC should consider whether the CLOIP process as it is currently designed is adequate to meet the needs of people with intellectual disabilities. Learning opportunities that occur only a few times in a year are unlikely to result in enhanced understanding to support informed choice. Likewise, abstract concepts such as those presented in the Making Informed Choices brochure may not be as meaningful as experiential activities.<br><br>Despite the low level of actual opportunities being provided to individuals, staff and families, DSSLC and the Contract MRA appeared to have formed a close working relationship that holds promise for the future. The CFR staff and Contract MRA staff interact regularly on an informal basis, but also hold joint meetings, generally on a monthly basis. The meeting attended by the monitoring team was well-attended by staff from both parties and there was a wide-ranging discussion about barriers to community awareness and possible solutions. Some of the strategies discussed included:<br><br>• The CLOIP staff did training for the Facility QMRPs about a year ago that could be repeated to address turnover at DSSLC.<br>• CLOIP staff could engage in a Question/Answer activity with families at a Provider Fair, including information about the roll-out of MRA monitoring of HCS.<br>• Provider agencies could be given tours of the Facility while present for the Provider Fair.<br><br>DSSLC has undertaken additional activities designed to promote adequate education | |

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| | | about available community placements to individuals and their families or guardians to enable them to make informed choices, but thus far these are reaching relatively few of the intended populations. Examples include:<br><br>• A Provider Fair was held on 10/24/09. The sign-in sheets documented attendance by 76 staff, 18 individuals and 4 family members, which constitute a small percentage of the total numbers for each group. The Director of CFR stated that at least two pending placements can be directly attributed to the Provider Fair, however.<br>• A Self-Advocacy event about community placement options was held on 9/1/09 and was attended by 29 individuals. The Director of CFR was the speaker.<br><br>A number of other promising initiatives were in the early stages of development or still on the drawing board. Some of these include:<br><br>• The development of a DVD/video of the "day in the life" of individuals who have transitioned to the community that can be viewed by individuals still residing at the Facility, allowing them to visualize community living in a concrete, familiar and meaningful way. Such a video could also be viewed on numerous occasions, thus enhancing the learning opportunity.<br>• CLOIP staff are in the first stages of developing a picture communication book that would feature individuals living at the facility and those who transitioned to the community engaging in similar activities in their respective environments.<br><br>The Facility would be well-served to work with appropriate parties to organize these many good ideas into a strategic plan with assigned responsibilities, timelines and outcome measures. Partners in this effort should include the Consumer and Family Relations Department, the Director of Program Coordination, the training department at the Facility, the Contract MRA and other MRAs, with input from the Facility's self-advocacy group. The monitoring team will look forward to reviewing the progress and achievements in this area during the next site visit. | |
| | 3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to | According to information provided by DADS during a conference call on 3/11/10, the assessment for placement process is the Community Living Options discussion that takes place at least annually as a part of the PSP as described in Texas DADS SSLC Policy: Most Integrated Setting Practices, 10/30/09. Under this definition, the Facility would have assessed all individuals within one year of the Settlement Agreement date. From observations and document reviews as described in some detail in T1a and T1b above, the Community Living Options discussion does not appear to be implemented in such a manner that it could yet be considered an effective assessment for placement. A number | |

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| | 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. | of improvements, many described above in T1a and T1b, should be made to how the process is implemented before the facility begins to consider that individuals have been truly assessed for placement. | |
| 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: | The monitoring team asked to review five complete CLDP packets, including all assessments and any documentation leading up to and occurring since placement. The packets included three for the individuals having Post-Move Monitoring visits during the site visit and one for an individual who had moved but was returned to the Facility within the first week. There were no CLDP meetings for individuals residing at DSSLC during the site visit, but the monitoring team did attend the CLDP for an individual from BSSLC who was transitioning to a community home in the Denton catchment area and who will therefore have Post-Move Monitoring from DSSLC. Interviews were also held with the QMRP/Social Worker and the Director of CFR regarding the CLDP process.<br><br>The Facility uses the basic format and forms for the CLDP, as prescribed in the State Policy on Most Integrated Setting 018. DSSLC did not have additional facility-specific policy and procedure regarding the CLDP process at the time of the site visit. The involvement of the Designated MRA was documented by their participation in the CLDP and in the completion of pre-placement activity as described in Section 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. | The CLDPs reviewed specified the actions to be taken by the Facility in identifying the essential and non-essential supports, the community living monitoring activities and the agreements section of the document.<br><br>It is not yet clear whether the process of identification of essential supports fully takes into account what a "successful" move would constitute or require, particularly in the critical first days and weeks. As an example, none of the CLDPs reviewed considered daytime activity, whether that is work or day habilitation, to be an essential support that must be in place at the time of the move. The monitoring team plans to examine this aspect of planning for transition in more depth at the next site visit. | |
| | 2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed. | In the CLDPs reviewed, both Facility staff and provider staff were assigned specific responsibility for the various actions needed to ensure that essential and non-essential supports were in place. These assignments were typically generic in nature, though; that is, assignments were made to "DSSLC staff" and "Provider." In only one instance, for Individual #596, did the CLDP assign responsibility to named staff. The intent of this | |

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| | | requirement of the Settlement Agreement would appear to be to ensure that specific staff are identified in order to ensure that nothing falls through the cracks. It is recommended the Facility begin to assign specific staff by name and position. An example would be Jane Doe, QMRP. This would ensure that the responsibility would be maintained even if the person in the position changed. | |
| | 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. | A review of the signature pages of the CLDPs in this sample indicated that three of the five did not have documentation that the individual or family/LAR were present at the CLDP. No other documentation was provided in the packet that documented the CLDP was reviewed with the individual or LAR. DSSLC should consider defining its processes for CLDP review by the individual and family/LAR, and the documentation of such, in a facility-specific policy and procedure. | |
| 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. | The monitoring team reviewed a total of five CLDPs. For each of these, the Facility provided the comprehensive assessments of needs and supports that were referenced. The reports were dated within the 45-day date of transition.<br><br>It is not always clear at what point in the process the receiving community placement had access to these assessments. In at least one instance, described in Section T1e below, the provider did not have the CLDP, including the assessments, until five days prior to the move. Only a draft of the essential supports was available at that time. Lack of access to these assessments would impair the provider's ability to successfully prepare the home and new staff for the individual's needs. | |
| T1e | Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such | Each CLDP packet included DADS Form 8630, Continuity of Care Pre-Move Site Visit Review Instrument for the Community Living Discharge Plan, which documented the Designated MRA's pre-move visit to the proposed placement. Each of these took place within a week prior to the move date. The form directed the MRA to verify the following:<br>• Whether the contract for the vendor to provide the services and supports was in good standing<br>• Whether DADS had identified any environmental or safety concerns at the time of its last residential review<br>• Whether the site administrator reported that the potential site presented any environmental concern that would impact the individual's identified needs<br>• Whether the MRA staff observed any environmental concern that would impact the individual's identified needs<br>• Whether the administrator/manager had a copy of the individual's draft CLDP and knew the outcomes important to the individual or LAR<br>• Whether the administrator/manager verified supports and services could be provided that were necessary to assist the individual in achieving the outcomes | |

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| | supports shall be obtained by the Facility before the individual's departure from the Facility. | The DADS Form 8630, Continuity of Care Pre-Move Site Visit Review Instrument for the Community Living Discharge Plan, does not require the MRA to document whether the specific supports and services identified in the comprehensive assessments that are determined by professional judgment to be essential to the individual's health and safety are in place at the transitioning individual's new home. This information was not documented anywhere in the CLDP packet that was provided. It is not clear how the Facility is verifying the supports are in place. This will require additional follow-up at the next site visit.<br><br>In one instance, for Individual #354, the DADS Form 8630 indicated that the MRA visited the transitioning individual's new home on two occasions, 1/28/10 and 2/5/10. It further indicated that the "Full CLDP not available from Denton SSLC. However, had draft Essential supports pages." No documentation was found that verified the essential supports were in place. Despite this, the MRA indicated that the setting should be recommended for IDT approval. This is potentially significant because this individual's placement on 2/9/10 lasted for three days before he was returned to DSSLC. A Community Placement Monitoring Note on 2/11/10 documented that the provider called the Facility to say that the individual "requires too much work for the group home," and that "He needs to return to DSSLC ASAP." The Director of CFR stated that he felt the provider had been very well informed of the individual's level of need during the CLDP process. A Community Placement Returns note in the CLDP packet stated that the provider did receive inservice on the individual's medical needs and equipment before his move and additional training on his feeding tube at some point before his return to the Facility. It is not certain whether the placement may have been more successful if the provider had full access to the CLDP, including the comprehensive 45-day assessments, in the days and weeks prior to the placement, but the likelihood of success would be greatly enhanced if the home is prepared and staff trained with this knowledge well in advance. Please see the next section, T1f, for the monitoring team's recommendation regarding quality assurance policies and procedures that need to be developed and implemented to ensure all CLDP activities are completed and done so in a timely manner. | |
| T1f | Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T. | The Facility did not provide any specific quality assurance policies and procedures to ensure that the CLDPs are developed, and that the Facility implements the portions of the plans for which the Facility is responsible. This may have played a part in the failed placement for Individual #354, as described in Section T1e immediately above. The Facility should develop and implement quality assurance policies and procedures related to the CLDP, including the collection of data on key indicators that may be used to identify and prevent issues and concerns that may result in a negative outcome. | |

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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. | DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009, Section V.D., requires the State Center's Quality Enhancement Department to submit an assessment of identified obstacles to the Director on a quarterly basis, and to DADS State Office on a yearly basis (by September 1 of each year). No analysis was provided in response to the document request. The Facility reported no facility-wide needs assessments related to the provision of community services to people with developmental disabilities and obstacles to such placement.<br><br>As described in Section T1b above, PST members at the Facility do not have a consistent understanding of the need and/or process for identifying barriers to movement. This will seriously compromise the Facility's ability to produce an analysis that will be a useful and meaningful tool for its own purposes or that of DADS at the State-level.<br><br>It would also seem important to incorporate the barriers and obstacles that family members and LARs report, particularly since LAR opposition is in itself one of the barriers to community placement most often encountered. DSSLC has a very active parents' group, with members who are very articulate about their concerns. In the PSPs attended, and in the interview with one parent, there were some very consistent themes expressed such as their sense their loved ones could not have the same freedom of movement in a community setting and the lack of availability of health care services. The Facility should collect this information in some organized fashion and include it in the comprehensive assessment of obstacles it is required to submit on an annual basis.<br><br>To overcome or reduce identified obstacles, the State must take action to ensure the community can provide choices of environment that are acceptable to the individuals and LRAs who are being encouraged and that can provide the supports identified in the community living discharge plan so that provisions T1C and T1E can be met. | |
| T1h | Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be | DSSLC provided its most recent Community Placement Report, dated 7/1/2009 - 1/31/2010. It was a listing of three individuals who have been placed in the community during the previous six months. It also included a list of 15 individuals who had been referred for placement. Eight of those latter individuals have since been placed, and three of the referrals were noted to have been rescinded. According to the Follow-up with Settlement Agreement Monitors document, SSLC community placement data from 9/1/09-2/28/10 indicate the statewide community placement rates range from approximately .7% to approximately 10%, with an average placement rate of approximately 3.6%. For the five Facilities with a census over 400, the range is from | |

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| | appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I. | approximately 1.2% to approximately 10%, and the average is approximately 4.8%. DSSLC's rate was approximately 1.8%, the second lowest of those Facilities most comparable in size. | |
| **T2** | **Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs** | | |
| T2a | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living | The monitoring team accompanied DSSLC staff on three Post-Move Monitoring visits, reviewed five CLDPs and Post-Move Monitoring documents for four individuals, and interviewed the staff assigned responsibility for Post-Move Monitoring tasks, as well as her supervisor, the Director of CFR.<br><br>The Facility employs a QMRP/Social Worker who is assigned the responsibilities of post-move monitoring. The position description clearly defines the expectations of this staff person to implement the Post-Move Monitoring process as required by Texas DADS SSLC Policy 018: Most Integrated Setting Practices. The QMRP/Social Worker is a well qualified individual with experience in HCS monitoring. She is relatively new to this position and is continuing to develop the processes and procedures to fully implement her responsibilities. | |

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| | discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency. | The caseload of the Post-Move Monitor is quite large despite the relatively small number of placements from DSSLC. This is a result of many individuals from other SSLCs moving into the DSSLC catchment area, which includes metropolitan Dallas/Fort Worth. In March 2010, the Post-Move Monitor was responsible for eight 90-day visits, one 45 -day visit and three 7-day visits. In February 2010, those figures were two 90-day visits, seven 45-day visits and seven 7-day visits. Given the size of the catchment area, the distances that must be traveled and the monitoring and follow-up requirements, these figures represent a potentially significant workload. The Post-Move Monitor is also expected to participate in the CLDP meetings for individuals transitioning from DSSLC as well as from other SSLCs when the individual is transitioning to a community placement in the DSSLC catchment area. In addition, it was reported that DADS central office has provided guidance that the Post-Move Monitor should attend a certain number of PSPs each month in order to perform quality assurance monitoring. The number cited was 20 PSPs per month. PSPs attended during this site visit averaged two to three hours each in duration, so this requirement alone would take 40-60 hours to complete. The Director of CFR acknowledged that the Post-Move Monitor has not been able to assume much of this quality assurance responsibility with her current workload. It was reported that both the Facility administration and DADS central office are aware of this phenomenon and that the Facility is currently seeking to hire two additional staff to perform Post-Move Monitoring functions on a statewide basis.<br><br>The Post-Move Monitoring Checklists for four individuals generally documented the attempts of the Post-Move Monitor to address identified issues with the appropriate parties. For example:<br><br>• For Individual #400's 1-7 day visit, the Post-Move Monitor documented follow up regarding the availability of transition funds and informing the Case Manager of concerns observed at the day habilitation program.<br>• For Individual 437's 1-7 day visit, follow-up was documented on the availability of transition funds, and reporting to the Case Manager that sunscreen, an essential support, was not available.<br>• For Individual 422's 1-7 day visit, the Post-Move Monitor followed up on transition funds and on a concern reported by the day habilitation program.<br><br>The Post-Move Monitoring visits that occurred during the site visit were completed in a timely manner, within the required timeframes. Of the other Post-Move Monitoring Checklists reviewed, there was one that did not appear to have been completed within the required timeframes. For Individual #596, the date of the move to the community placement was 12/30/09. The first Post-Move Monitoring visit did not appear to take place until 1/8/10, 9 days after the move. A notation on the Post-Move Monitoring | |

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| | | Checklist indicated that this was considered the 8-45 day visit. The second documented visit occurred on 2/18/09, and was noted as the 46-90 day visit. No Post-Move Monitoring Checklist was documented for the initial 1-7 day visit. The workload issue described above may be expected to affect timeliness. | |
| 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. | The monitoring team accompanied the Post-Move Monitor on visits for three individuals. Prior to the visits, the team also reviewed the CLDPs and any previous Post-Move Monitoring Checklists for the three individuals. The Post-Move Monitoring process as observed during the site visit may not ensure that all supports are in place throughout the initial 90 day period following placement.<br><br>Each visit took place during hours in which the individuals were in day programs. The Post-Move Monitor visited the day programs the individuals were attending and then met program staff at the home. The Post-Move Monitor did not observe the individuals in their home environments. When questioned about her practice, she stated she usually saw the individuals in the day program. Relying solely on staff report and written documentation to assess how well the services and supports are provided is not a sufficiently reliable practice. Individuals should be seen in their home environments with direct care professional present in order to observe interactions and evaluate level of comfort. It may be difficult with the current workload to visit both the home and day program at every interval. If so, the Facility should determine an appropriate guidance as to how often and at what intervals the individuals must be seen in their homes with direct care professional present until such time that additional Post-Move Monitoring staff are hired.<br><br>Each of the three visits was for the 8-45 day interval. Previous Post-Move Monitoring Checklists for the 1-7 day visits indicated that essential supports were in place. In at least two instances, the Post-Move Monitor was not immediately aware that essential supports that were reported to be in place during the 1-7 day visit were no longer in place. These included a personal mirror in the bedroom for Individual #422 and a deep divided dish for Individual #400. It is recommended that the Post-Move Monitor check for the presence of essential supports at each visit.<br><br>It is also recommended the Post-Move Monitor at least spot check documentation in addition to staff interview responses in order to ensure all supports and services are in place. There were very few records available in the home visited and the Post-Move Monitor appeared to rely heavily on the report of staff as to whether certain activities had occurred without asking for verification. | |

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| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations. | DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices is consistent with the Settlement Agreement in that it specifies that the provisions of the Policy 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; and that the provisions of the policy do apply to individuals committed to the Facility following the court-ordered evaluations. No Facility-specific policy and procedure related to Most Integrated Setting for alleged offenders was provided in response to the document request.<br><br>DSSLC reported only one alleged offender residing at the Facility, Individual #616. His most recent PSP and CLOIP Worksheet were reviewed. These were consistent with the PSPs and CLOIP Worksheet of other individuals residing at DSSLC. | |
| **T4** | **Alternate Discharges -** | | |
| | Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; | DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices requires the Facility to follow CMS required discharge processes for certain categories of individuals rather than the discharge processes prescribed in that policy and by the Settlement Agreement. These are known as "alternate discharges." The State-level policy does not provide any additional guidance to the Facility. DSSLC Policy and Procedure<br><br>In response to the document request, the Facility reported no alternate discharges since July, 2009. There is no basis for a full evaluation of practice in this area of the Settlement Agreement at this time, but the Facility did provide its most recent CMS Statement of Deficiencies and Plan of Correction (CMS Form 2567), printed on 3/20/09. Although this was not within the timeframe of the Settlement Agreement, the document was reviewed as it was included in the document request response. The 2567 indicated the Facility failed to meet some requirements of CMS related to discharge, specifically related to tags W123 and W 203. This will bear further examination at the time of the next site visit. | |

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| | (d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | | |

**Recommendations:**

1. DSSLC should develop facility-specific policies and procedures to describe how it will implement the general requirements of the Settlement Agreement and Texas DADS SSLC Policy: Most Integrated Setting Practices 018. This should include defining its processes for CLDP review by the individual and family/LAR.
2. Additional training and mentoring in the person-directed planning process is needed to transform the PSP into a truly person-centered plan. The Director of Program Coordination expressed an interest in obtaining information regarding person-centered training models that might assist QMRPs to better facilitate this process. Information may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.
3. The Facility should consider ways to revise the PSP format and meeting structure so that the vision of an optimal living situation begins with those things that are most important to the person and drives development of the rest of the plan.
4. PST members would benefit from intensive and ongoing training related to the general identification of barriers and the consequent design and implementation of strategies to reduce those barriers. The training should also focus specifically on the role and responsibilities of the team in the identification of family/LAR opposition as a barrier and in the development of strategies to resolve that barrier. Additional guidance from DADS at the State-level would be useful.
5. The Facility should collect data from families/LARs regarding their perceived barriers to community placement and include this information in the comprehensive assessment of obstacles it is required to submit on an annual basis.
6. The Facility would be well-served to work with all appropriate parties to organize the many good ideas for promoting awareness of community options into a written strategic plan with assigned responsibilities, timelines and outcome measures. This should be a joint effort of the CFR, the Director of Program Coordination, training staff, the Contract MRA and other appropriate MRAs, as examples. The DSSLC self-advocacy group should also be involved in the process. The plan should include strategies to increase opportunities for more individuals to take community tours and experience community living options, in accordance with State policy that each individual is to be afforded these opportunities. This will also likely enhance the formal CLOIP assessment process, as individuals at the Facility will have a better foundation to understand its meaning. The plan should also address opportunities for families/LARs to learn more about community living options, to complement the MRA CLOIP activities. The Facility will want to consider talking with the parents' group to help identify what kinds of opportunities would be most accessible and helpful to families. The plan should also be undertaken with sensitivity to the concerns of families/LARs, and crafted to help alleviate those concerns over time.
7. Evaluate and further define the process used to assess a person for community placement, including prioritization criteria.
8. In order to ensure that all actions specified in the CLDP are completed, it is recommended the Facility begin to assign specific staff by name and

position. An example would be "Jane Doe, QMRP," rather than "DSSLC staff." This would ensure that the responsibility would be maintained even if the person in the position changed.

9. All supports, but particularly essential supports, should be reviewed at each Post-Move Monitoring visit, regardless of whether the supports were available during previous visits.
10. The Post-Move Monitor should spot check documentation in addition to obtaining staff interview responses at each visit.
11. The Post-Move Monitor should visit individuals in their home environments with direct care staff present as a routine part of the process, even though this may require many visits to be made in the late afternoons, evenings, and/or weekends.
12. Formalize the implementation of the Post-Move Monitoring Checklist to ensure its use as a meaningful tracking tool for both essential and non-essential services and supports. The Facility should consider entering the data from each visit in an electronic format that will allow for data tracking, data manipulation, reporting and analysis. This will enable the Facility to track corrective action in the short-term, but will also be useful for identifying quality improvement needs across, for example, provider compliance rates or supports availability.
13. The Facility, DADS and the appropriate MRAs should examine the community living options in the DSSLC catchment area to ensure that needed supports and services are available to meet the needs of the individuals considering placement, particularly, but not limited to, day programs and employment opportunities. Community living options should provide an environment that is at least as rich as that provided at DSSLC.
14. Evaluate, and incorporate into Facility policy, the quality assurance procedures for transition and discharge, including specifically the 10% monthly random sample as required by DADS Policy 018 on Most Integrated Setting Practices.
15. Develop a methodology for the DADS- required assessment of barriers such that it can be used as a quality assurance tool, and one that can inform the development of Facility plans for raising awareness of staff, individuals living at BSSLC and their families/LARs. In the long-term, it should also be useful in formulating regional resource development strategies with providers and other stakeholders.

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. Texas DADS SSLC Policy: Most Integrated Setting Practices, 10/30/09, and six attachments (exhibits)<br>2. DSSLC Policy and Procedure: Client Management -30, Guardianship, dated 3/10/09<br>3. List entitled Legal Guardians Assigned<br>4. Copy of letter dated 2/5/10 from DSSLC to primary correspondents of individuals identified as having a "highly significant need" for a legal guardian<br>5. Prioritization spreadsheet dated March 2010<br>6. PSPs for 29 individuals: Individuals # 26, # 89, #95, #127, #133, #134, #163, #213, #221, #248, #272, #275, #276, #297, #350, #367, #406, #430, #495, #497, #563, #594, #606, #155, #645, # 685, #689, #758, #760<br>7. Rights Assessments for four individuals: Individuals #429, # 594, #616, #685<br><br>**People Interviewed:**<br>1. Andy Maher, Director of Consumer and Family Relations (CFR)<br>2. Parent/LAR of Individual #250<br><br>**Meeting Attended/Observations:**<br>1. PSPs for three individuals: Individuals #87, #138, #673 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>A large majority of individuals living at DSSLC have court-appointed guardians. Most of these are family guardians, but there have been several referrals to Health Services of North Texas and directly to the probate court in Denton County.<br><br>The Facility does not have a clearly defined policy or process for assessing an individual's need for an LAR, nor for prioritizing that need, although there has been some work done on developing a methodology for the latter. PSTs would benefit from education and guidelines in the area of assessment for functional capacity to render a decision regarding the individual's health or welfare. It must be a thoughtful process such that individual retains as much autonomy and as many opportunities for choice as is possible. |

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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 | The monitoring team observed three PSPs, reviewed an additional 29 PSPs and three Rights Assessments, and interviewed the Director of CFR to assess the Facility's status in this area. No state level policy had yet been promulgated to implement this section of the Settlement Agreement, but one was reported to be forthcoming. DSSLC does have a | |

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| | 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. | facility-specific Policy and Procedure: Client Management -30, Guardianship, dated 3/10/09. The Facility also provided a list of 375 individuals entitled Legal Guardians Assigned. According to the Director of CFR, about 2/3 of the individuals living at DSSLC have an LAR. All but about sixteen are family members. Of the sixteen non-family guardians, Health Services of North Texas is the LAR for 15 individuals and Guardianship Services, Inc holds guardianship for the remaining individual.<br><br>The Facility did not provide a specific assessment tool or process it uses to assess an individual's functional capacity to render a decision regarding the individual's health or welfare, nor does the Facility policy provide any guidance other than to state that the need for guardianship is reviewed, at least annually, at the individual's PSP, and that a determination will be made at that time as to whether the person can provide informed consent. The Director of CFR stated that the PSTs do consider guardianship at the PSP meeting, but he was unsure of the actual assessment process. For the three PSPs observed, the PSTs did complete a Rights Assessment. The Rights Assessment is used by the PST to consider whether an individual requires a rights restriction in a number of areas. These include whether an individual advocates for self or needs assistance from an advocate, and whether the individual can provide informed consent in several areas: medical, programmatic, financial, restrictive/intrusive practices, media/photo and release of records. All but one of the individuals whose Rights Assessments were reviewed already had an LAR. For the one individual who did not (Individual #594), the PST recommended that he be referred to obtain a guardian. The Rights Assessment included this comment: "According to (his) Functional Skills Assessment dated 03/05/09, Robert does not have the cognitive ability to provide informed consent." It is not clear whether the instrument referenced is a reliable or appropriate tool for assessing ability to give informed consent. This should be evaluated by the Facility.<br><br>The PSP also includes a section that requires a discussion regarding the need for guardianship. In the three PSPs observed and in all 30 of the PSPs reviewed, there was no evidence of any consistent or standardized process being used to assess the individual's functional capacity to render a decision regarding his/her health or welfare and how that may have affected its consideration of the need for an LAR. It is recommended that state guidance be provided that provides specific parameters and criteria for the assessment process.<br><br>The Facility policy CM-30 does assign responsibility to the Director of CFR and to the QMRP to act to protect the rights of an individual when guardianship is being sought. It specifically requires these Facility representatives to confer with the attorney ad litem assigned to the case and to keep the individual informed of the guardianship process as it progresses, even when this conflicts with the wishes of the prospective guardian. This is in keeping with the responsibility of the Facility and each PST to protect and preserve the | |

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| | | rights of all individuals living at the Facility. The Director of CFR reported that he regularly interacts with the attorney ad litem when a guardianship is in process. The monitoring team would suggest that a training module be developed for QMRPs to ensure they understand their responsibilities in this area and how to fulfill them. The Director of CFR and the Director of Program Coordination should work with training staff to develop and implement an appropriate training. This may be effectively combined with training for QMRPs on the guardianship assessment process once it is finalized.<br><br>The Facility has recently begun to use a prioritization methodology based on the criteria described in the Settlement Agreement. This methodology was devised by the Director of CFR. It was not yet formalized into written policy and procedure, but was beginning to be implemented on an informal basis. The Facility should ensure there are written criteria and guidelines for this process as it is currently being implemented. | |
| 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. | The Director of CFR has used the initial results of the prioritization process described above to identify a group of individuals without current guardians who would be considered of highest need. He sent letters to the primary correspondents on 2/5/10 notifying them of the individual's perceived status. There has been little response at this time. According to information provided in the document request, twenty individuals were highlighted as having received an LAR since 7/1/09. The Facility does not typically track the dates guardianship is granted; rather, it tracks expiration dates so as to assist LARs with reminders.<br><br>As noted in Section U1, there are 16 individuals who have a corporate guardian. The Director of CFR also reported that referrals for guardianship have been made directly to the Denton County Probate Court. In addition, there are 359 individuals with a family guardian. In an interview with parent and LAR who is very active in the DSSLC Parents' Association, he stated that members of the Association who are guardians for their own family members were interested in becoming guardians for other individuals who live at DSSLC.<br><br>Given the large number of LARs, and the potential for that number to grow, the Facility should consider what its responsibility should be in ensuring that guardians understand the roles and responsibilities involved. The SA requires the Facility to 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. It is reasonable to expect that the Facility's processes in soliciting guardians would include some criteria as to the qualifications of the persons to be solicited for this important task. It is also reasonable to expect that guidance on the process of becoming an LAR would include an understanding of the role of the LAR in protecting the civil rights of the individuals served. The Facility had not developed a formal description of the criteria it will use to | |

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| | | identify and solicit potential guardians.<br><br>The Facility also has the responsibility to 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** (emphasis added), as required in Section S1. Reasonable efforts for the solicitation of LARs should be expected to take support for this principle into account and educational opportunities provided to ensure LARs have sufficient guidance in these areas. No educational opportunities of this sort are currently being provided.<br><br>There should also be consideration given to the other potential options to obtaining a full guardianship, such as a limited guardianship or a health care proxy, for an individual. DSSLC and DADS may want to explore all other available options that might allow an individual to receive assistance as needed in making health and welfare decisions without the necessity of being declared legally incompetent. | |

**Recommendations:**

1. DSSLC should ensure there are written criteria and guidelines for the process it is currently using to assess the need for an LAR. It is recommended that state guidance be provided that provides specific parameters and criteria for the assessment process.
2. It is not clear whether the Functional Skills Assessment is a reliable or appropriate tool for assessing ability to give informed consent, although it has been referenced as the justification for restricting this right. This should be evaluated by the Facility.
3. DSSLC should ensure there are written criteria and guidelines for the process it is currently using to prioritize the need for an LAR. It is recommended that state guidance be provided that provides specific parameters and criteria for the prioritization process. DADS should gather and review all the processes for prioritization being used at the various facilities and promulgate a state guidance as soon as possible.
4. Training should be provided for QMRPs and PSTs in the processes developed pursuant to the state guidance and subsequent development of facility-specific policies and procedures.
5. There should be consideration given to the other potential options to obtaining a full guardianship, such as a limited guardianship or a health care proxy, for an individual. DSSLC and DADS may want to explore all other available options that might allow an individual to receive assistance as needed in making health and welfare decisions without the necessity of being declared legally incompetent.
6. Given the large number of LARs, and the potential for that number to grow, the Facility should consider what its responsibility should be in ensuring that guardians understand the roles and responsibilities involved, including the responsibility to assist individuals to retain as much autonomy as possible.
7. The Director of CFR and the Director of Program Coordination should work with training staff to develop and implement an appropriate training for QMRPs to fulfill their responsibilities in protecting the rights of individuals when guardianship is being sought. This may be incorporated into the training referenced in the previous recommendation.

| SECTION V: Recordkeeping and General Plan Implementation | |
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| | **Steps Taken to Assess Compliance:**<br>**Documents Reviewed:**<br>1. DADS Policy Number 020, State Supported Living Center Policy: Recordkeeping Practices, Dated 8/31/09<br>2. DSSLC Policy Client Management-25, Recordkeeping Practices, Dated 10-19-2009<br>3. Denton State School Record Order and Purging Schedule<br>4. Active Record for Individuals #163, #339, #629, #772<br>5. PSPs and associated evaluation reports for Individuals #713 and #720<br>6. PSPs for Individuals #81, #95,#508, #645, #759<br>7. Chart Review Monitoring results document for March, 2010<br>**People Interviewed:**<br>N/A<br>**Meeting Attended/Observations:**<br>1. Presentation of records by Lori Powell, Settlement Agreement Coordinator, March 29, 2010<br>2. PSP Meeting for Individual #772<br>3. Morning Meeting, Houston Park, March 30, 2010 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>DADS is in process of revising the policy for recordkeeping. DSSLC follows the current DADS policy and has established a Facility policy that adds local procedures.<br><br>All documents had sections and documents in the same order, were typed or written with non-erasable pen, were in chronological order, and had no gaps between entries.<br><br>DSSLC reviews a sample of records for quality. The review includes questions that check items that go beyond the records themselves. Specific items are reported on. The monitoring team did not determine how this information is used for corrective actions or trending.<br><br>Use of records in decision-making is variable. Records were not referred to during PSP meetings, but a record was used to resolve a question during an HRC meeting. |

| # | Provision | Assessment of Status | Compliance |
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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 | An individual's active record consisted of at least two books. The Red book was the Residential Program Record; the Green book was Residential Medical Record.<br><br>All documents reviewed were legible, complete, and dated. Only one document, a copy of a PBSP provided for the PSP review for individual #720, was not signed, although the name of the responsible person was typed. Of the four active records reviewed in their | |

| # | Provision | Assessment of Status | Compliance |
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| | guidelines in Appendix D. | entirety, all had sections and documents in the same order, were typed or written with non-erasable pen, were in chronological order, and had no gaps between entries. In only one case was an entry signed by another person, with "by" clearly written. For two of the four, an individual record was readily available; for the other two, the monitoring team did not request the individual record.<br><br>Refer to Provision M6 for examples of initials and documentation missing from MARs. | |
| V2 | Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | DSSLC policy closely follows DADS policy. Additional information needed to operationalize the DADS policy was added to the DSSLC policy, such as procedures for use of a check-out card and information about inaccurate recordkeeping and what to do when that is discovered. The monitoring team was informed that the format of the record will be changing as a statewide DADS policy is implemented. | |
| V3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance 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. | DSSLC has a process for review of unified records. This review includes items that are more comprehensive than a simple review of the contents of the record. For example, the reviews checks whether the HSP met at least every six months. A percentage for many of the items is calculated. The monitoring team did not determine the accuracy of the monitoring. As an example, the March, 2010, review reported that integrated progress notes show communication between disciplines to be 90%; this does not seem consistent with reviews by the monitoring team of the quality of cross-discipline integration that indicate a need for greater integration. Nevertheless, some items were reported as having a significant number of errors. The completeness of the MAR is reported as being 21%; this indicates that the reports are intended to identify items needing improvement. The monitoring team did not review corrective actions at this time. No reports of trending were provided to the monitoring team. | |
| 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, | Use of records in making care, medical treatment, and training decisions is variable. At the PSP meeting, there was no reference to data found in the Active Record; the monitoring team could not make a conclusion as to whether the staff reporting assessments used information from the Record in developing those assessments. At the HST meeting, a blood pressure chart was presented but the Record was not used for | |

| # | Provision | Assessment of Status | Compliance |
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| | medical treatment and training decisions. | review; the monitoring team could not make a conclusion as to whether the Record was used in developing information for the meeting. At the HRC meeting, the Record was checked for one individual to resolve an inconsistency about who was guardian; this information was easily found. | |

**Recommendations:**

1. DADS should continue development of the new policy. Prior to implementation, DSSLC should revise its Facility policy to operationalize the state policy. Implementation should include provisions for competency-based training of all staff who will use the records.

## Health Care Guidelines

| SECTION I: Documentation | |
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| | **Steps Taken to Assess Compliance:**<br>Record Review of Individuals #s 138, #568, #404, #335, #419, and #569 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Review of individuals' #138, #568, #404, #335, #419, and #569 records indicated that the only nurses, physicians, dentist, and OT/PTs almost always documented in the SOAP format. Review of integrated progress notes primarily contained documentation by nurses and physicians; rarely did the notes contain documentation from other disciplines. Late entries were properly notated. Gaps between entries were rarely found. Entries almost always were dated with date and time. Entries were either written with a ball point pen or typed. Documentation of content was reasonably legible but signatures, titles, and initials were not consistently legible. Signatures usually included the writer's first initial, last name and title. Typically, entries were written in chronological order. The facility needs to ensure that all disciplines write legibly, particularly their signatures, titles, and initials. The facility needs to instruct all disciplines to write, chronologically, in the integrated progress notes as required by the SA and HCG for compliance.<br><br>There was evidence from review of the above individuals' Annual and Quarterly Nursing Assessments accompanying HMPs and integrated progress notes that these records were used to make health care and training decisions.<br><br>Annual medical reviews included organized problem lists as required. Psychiatric documentation in the clinical record was typically present and communications were clear. Psychiatrists documented results of scheduled PTR meetings and wrote updates as the needs arose. The format of the documentation did not always follow the Data-Assessment-Plan format (DAP) or Subjective-Objective-Assessment-Plan (SOAP) methods. |

**Recommendations:**
1. The facility needs to ensure that all disciplines write legibly, particularly their signatures, titles, and initials.
2. The facility needs to instruct all disciplines to write, in the integrated progress notes as required by the SA and HCG for compliance.

| SECTION II: Seizure Management | |
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| | **Steps Taken to Assess Compliance:**<br>1. Record Review of Individuals #404, #335, #419, and #569<br>2. Review of complete seizure records, Individual # 297, #511, #522, # 571, and #577<br>3. Review of complete neurology clinic charts: Individual #170, # 221, #286, # 412, and # 580 |

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| | 4. Attended neurology consultation clinic on 3/31/10<br>5. Interviews with Dr Lynn Wong, consulting neurologist, and Bryan Jacobs LVN, specialty clinic coordinator |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Review of individuals' #404, #335, #419, and #569 seizure records and accompanying documentation indicated that the seizure activity was documented thoroughly and in accordance with SA, HCG and facility policy. Nurses completed appropriate assessments on the seizure form and monitored the individual until fully recovered from the postictal state. Their HMPs were in accordance with SA and HCG.<br><br>The presence of an on-site neurology clinic was a strength of DSSLC, and long term management of epilepsy and other neurological conditions was enhanced by the practice of maintaining longitudinal records in the clinic area. The assignment of a nurse who has ongoing responsibilities for coordination of specialty clinic was also beneficial.<br><br>Individual #577 – This individual had a longstanding seizure disorder and multiple medical difficulties including status post CVA and pneumonia, sepsis, renal insufficiency and hypertension secondary to sepsis. Current epilepsy management was with Valproic acid (VPA) and levetiracetam, a standard combination treatment to attempt seizure control. The individual experienced six seizures during the period of May, 2009 through September, 2009. The individual was followed closely by the neurology clinic and had already been seen three times during calendar year 2010. Comprehensive pharmacy reviews were noted. These included comments on drug interactions and guidance regarding absorption levels of VPA monitored. General laboratory monitoring was noted including comprehensive chemistries and hematology assessments as mandated by the circumstances. VPA levels were therapeutic. Levetiracetam levels not located.<br><br>Individual #297. This individual presented new onset idiopathic seizures with noted frequency of three seizures over the course of a year. He was seen for neurology consultation on 02/09 and 08/09. Seizure management was initially maintained with phenytoin, with transition to valproate for seizure control in the setting of existing treatment for psychiatric indications. Diastat was available for use as needed. A good physical exam was noted and excellent collaboration questions were noted from the psychiatrist, who inquired about the possible use of VPA to treat both behavioral and neurological problems. These issues were addressed in the neurology clinic in August 2009, and the discussion between the psychiatrist and neurologist was well documented. Comprehensive RN neuro checks were done on 08-01-09 and 08-02-09 following a superficial injury to the eyebrow. Levels of VPA were noted; QDRRs reviewed use of antipsychotic medications and addressed anticonvulsant management documentation. Appropriate secondary consult was noted with endocrinology regarding elevated prolactin.<br><br>Individual # 522. This individual was treated with four anticonvulsants: topiramate, phenytoin, lamotrigine and levetiracetam. The individual was also treated with a vagal nerve stimulator. At one point during the year the individual experienced breakthrough seizures. These were possibly related to a |

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| | concurrent pneumonia. Seizure records were complete, choice of anticonvulsants was appropriate, and evaluation of the breakthrough seizure was medically appropriate. The chart contained good descriptions of the clinical seizures and documented good follow-up care by the medical attending, around the time of active seizure.<br><br>Individual # 511. This individual was a 45 year old with seizures, spastic paraplegia and neurogenic bladder. The treated was treated with carbamazepine. The individual was well known to neurology clinic and was seen in 2008. The individual experienced about a dozen seizures during the past year. Some seizures required 911 calls and evaluation secondary to hypotension. The individual was hospitalized in November for a urinary track infection and seizures. Detailed seizure records were noted on 06-25-09, 06-28-09, 07-14-09, 07-15-09, 11-02-09, 09-01-09, and 02-10-09. Good follow-up documentation by nursing was noted in progress notes. Cumulative seizure records appeared accurate and complete. Neurological consultation was obtained on 01-20-10. Therapeutic carbamazepine levels were noted and the neurology consultant recommended the addition of levetiracetam with follow-up appointment in three months. |

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| **Recommendations:**<br>1. Continue ongoing review of HCG for seizure management. |

| **SECTION III: Psychotropics/Positive Behavior Support** | |
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| | **Steps Taken to Assess Compliance:**<br>1. Review of individual, #404's record<br>2. Review of Psych-Med Clinic minutes, 03/29/10 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Psychiatric evaluations were reviewed. These followed the guidelines of SA appendix B, slightly modified as discussed in section J. The evaluations were generally strong. A weakness noted was the lack of specific discussion of the psychiatric differential diagnosis. Such discussion would help clarify strengthen the evaluations, particularly when historical diagnoses are reviewed and changed.<br><br>Laboratory monitoring was an area of strength for DSSLC. Laboratory monitoring was enhanced through excellent input from the pharmacy in both HST and QDRR reviews.<br><br>The area of psychiatric monitoring of individuals receiving anticonvulsant medications could be improved. While the list of "dual purpose" medications may include all individuals in whom the use of such medications by the psychiatrist is deliberate, there appear to be individuals who are prescribed anticonvulsants for seizure management, but in whom knowledge of their psychiatric status suggests that the anticonvulsants may be having effects of their behavioral status. |

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| | All cases reviewed used the new format for case review, which closely followed psychiatric treatment guidelines provided in Appendix B of the SA. Many of the cases included reviews of past treatment. In these cases the psychiatrist doing the reevaluation commented on past diagnostics. Evaluations typically did not include information on the settings where the client was seen. Medical illnesses were commented upon. The evaluations typically did not include information from the PST. Target behaviors and symptoms were mentioned, typically briefly. Review or discussion of differential diagnosis per DSM IV TR was brief and was typically limited to comparison of past diagnoses vs. the new diagnosis.<br><br>The rationale for changing medications was provided in the psychiatrist's notes made during the PTR. In none of the cases reviewed did the psychiatrist change medications without having had recent contact with the individual. Quarterly notes commented on the current exam.<br><br>DSSLC pharmacy provided three lists of anticonvulsants – those use for neurological indications, those used for psychiatric indications, and those use for both psychiatric and neurological indications. These lists should be reviewed for accuracy. For example, individual #539 is prescribed gabapentin as a mood stabilizer and valproate as an anticonvulsant. Accordingly, the dose of the latter is not tracked by the behavior team in the PTRs, although it may well be the case that valproate is in fact acting as a mood stabilizer. Individuals receiving anticonvulsants for psychiatric indications such as individual # 79 and individual #720, received the required laboratory monitoring<br><br>Because nurses complete the MOSES assessment, administer, and monitor side effects and/or adverse drug reactions to psychoactive medication, it was important for the nurses to collaborate with other PBST members in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior. There was evidence in individual #335's Annual Nursing Assessment summary that psychoactive medications were reported effectively and included in the HMP, but that was not always the case with other individuals receiving psychoactive medications. Nurses need to develop and implement HMPs for individuals receiving psychoactive and/or antiepileptic medications with individualized goals and interventions. The HMP needs include interventions for specific side effect monitoring of psychoactive medications by the DCPs and to reference behavioral interventions outlined in the PBSP. |

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| **Recommendations:**<br>Nurses need to consistently develop and implement HMPs for individuals receiving psychoactive medications with individualized goals and interventions. The HMP needs include interventions for specific side effect monitoring of psychoactive medications by the DCPs and to reference behavioral interventions outlined in the Behavior Plan. |

| **SECTION IV: Management of Acute Illness and Injury** | |
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| | **Steps Taken to Assess Compliance:** |

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| | Record Review of Individuals # 138, #568, #404, #335, #419, and #569 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Refer to Sections M2, 3, 4, and 5 information |

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| **Recommendations:**<br>There are no additional recommendations offered at this time. |

| **SECTION V: Prevention** | |
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| | **Steps Taken to Assess Compliance:** |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Refer to Section M |

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| **Recommendations:**<br>There are no additional recommendations offered at this time. |

| **SECTION VI: Nutritional Management Planning** | |
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| | **Steps Taken to Assess Compliance:** |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Refer to Section O. |

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| **Recommendations:**<br>There are no additional recommendations offered at this time. |

| **SECTION VII: Management of Chronic Conditions** | |
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| | **Steps Taken to Assess Compliance:** |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:** |

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| **Recommendations:**<br>There are no additional recommendations offered at this time. |

| **SECTION VIII: Physical Management** | |
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| | **Steps Taken to Assess Compliance:** |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:** |

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| **Recommendations:**<br>There are no additional recommendations offered at this time. |

| **SECTION IX: Pain Management** | |
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| | **Steps Taken to Assess Compliance:**<br>Record Review of Individuals #138, #568, #404, #335, #419, and #569 |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | **Summary of Monitor's Assessment:**<br>Review of individual #404's records indicated that a standardized Pain Assessment Tool (Pain Scales: A – Wong/Baker, B – PAINAD, and C – FLACC and Verbal Pain Scale) was used to assess his acute and chronic pain. Review of his Pain Management WorkSheet, 09/28/09 through 01/20/10, indicated that pain medication was administered and assessed for effectiveness. In addition, he had an appropriate HMP for Pain/discomfort related to bilateral osteoarthritis of knees and mild wedge deformity a T-11.<br><br>Review of individual #569's records indicated that a standardized Pain Assessment Tool (Pain Scales: A – Wong/Baker, B – PAINAD, and C – FLACC and Verbal Pain Scale) was used to assess his acute and chronic pain. Review of his Pain Management WorkSheet, 02/16/10 through 02/28/10, indicated that when pain medication was administered it was assessed for effectiveness.<br><br>Review of individual #569's records indicated that a standardized Pain Assessment Tool (Pain Scales: A – |

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| | Wong/Baker, B – PAINAD, and C – FLACC and Verbal Pain Scale) was used to assess his acute and chronic pain. Review of his Pain Management WorkSheet, 03/02/10 through 03/15/10, indicated that when pain medication was administered it was assessed for effectiveness. |

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| **Recommendations:**<br>There are no additional recommendations offered at this time. |

| **HCG appendix A: Pharmacy and Therapeutics** | |
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| | **Steps Taken: Records reviewed, per Section J** |
| | **Facility Self-Assessment:** A facility self-assessment was not provided because this was a baseline review. |
| | Summary of Monitor Assessment: Medical staff members participated in P&TC deliberations. Per the Pharmacy Director, Drug Utilization Evaluation (DUE) data were considered. Recent broad reviews have been conducted on the facility wide use of olanzapine and clonazepam. Medication errors and variances were reviewed by the Medication Error Committee. Tardive dyskinesia monitoring was done quarterly using DISCUS; review was done by physicians. All charts reviewed contained PTR reviews. In all cases reviewed, comments were reviewed by PCP and/or the psychiatrist, s appropriate. |

## Acronyms Used in this Report

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| AAC | Augmentative and alternative communication |
| ACLS | Advanced Cardiac Life Support |
| AWR | Average Weight Range |
| BCBA | Board Certified Behavior Analyst |
| BSRC | Behavior Support Review Committee |
| CEU/ceu | Continuing Education Unit |
| CFR | Consumer and Family Relations |
| CNE | Chief Nurse Executive |
| CPR | Cardiopulmonary Resuscitation |
| CTD | Competency, Training, and Development |
| CXR | Chest X-ray |
| DADS | Texas Department of Aging and Disability Services |
| DAP | Data-Assessment-Plan Format |
| DCP | Direct Care Professional |
| DD | Developmental Disability |
| DFPS | Department of Family Protective Services |
| DMID | Diagnostic Manual - Intellectual Disability |
| DPC | Director of Program Coordination |
| DRMC | Denton Regional Medical Center |
| DSM IV TR | Diagnostic and Statistical Manual of the American Psychiatric Association |
| DSSLC | Denton State Supported Living Center |
| FLACC | Face, Leg, Activity Cry, and Consolability – Pain Assessment Scale |
| FTE | Full-time Equivalent |
| GERD | Gastro Esophageal Reflux Disease |
| GM/gm | Gram |
| HCG | Health Care Guidelines |
| HMP | Health Maintenance Plan |
| HRC | Human Rights Committee |
| HS/hs | Bedtime |
| HST | Health Support Team |
| IC | Infection Control |
| ICF/MR | Intermediate Care Facility/Mental Retardation |
| IM | Intramuscular |
| IPN | Integrated Progress Note |
| IV | Intravenous |
| LAR | Legally Authorized Representative |
| LTAC | Long Term Acute Care |
| LVN | Licensed Vocational Nurse |
| MAR | Medication Administration Record |
| Mg/mg | Milligram |
| MD/M.D. | Medical Doctor |

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|---|---|
| ML/ml | Milliliters |
| MOM | Milk of Magnesia |
| MOSES | Monitoring of Side Effect Scale for Psychoactive and Antiepileptic Medications |
| MRSA | Methicillin Resistant Staphylococcus Aureus |
| NA | Not Applicable |
| NMT | Nutrition Management Team |
| NOS | Not Otherwise Specified |
| $O_2$SATS | Oxygen Saturation |
| OT | Occupational Therapist |
| PAINAD | Pain Assessment in Advanced Dementia Scale |
| P&TC | Pharmacy and Therapeutics Committee |
| PAO | Physical Aggression toward Other |
| PBSP | Personal Behavior Support Plan |
| PBST | Personal Behavior Support Team |
| PCP | Primary Care Physician |
| PDB | Physically Disruptive Behavior |
| PFW | Personal Futures Workshop |
| PIC | Performance Improvement Committee |
| PNM | Physical and Nutritional Management |
| POI | Plan of Improvement |
| PSP | Personal Support Plan |
| PST | Personal Support Team |
| PT | Physical Therapist |
| PTR | Psychiatric Treatment Review |
| QA | Quality Assurance |
| QDRR | Quarterly Drug Regimen Review |
| QMRP | Qualified Mental Retardation Professional |
| RN | Registered Nurse |
| SA | Settlement Agreement |
| SAC | Settlement Agreement Coordinator |
| SAM | Self Administration of Medication |
| SIB | Self Injurious Behaviors |
| SOAP | Subjective Objective Analysis Plan (method of charting) |
| TAC | Trends Analysis Committee |
| TB | Tuberculosis |
| UTI | Urinary Tract Infection |
| VDB | Verbally Disruptive Behavior |