United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

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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 (SA) 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 Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, 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 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 or her every six months, and detailing his or 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 were considered baseline reviews. The baseline evaluations were intended to inform the parties and the Monitors of the status of compliance with the SA.

Reviews conducted subsequent to the baseline reviews are considered status reports and are to provide an evaluation of the extent to which the facility has complied with the requirements of the Settlement Agreement.
This report provides a status report for the El Paso State Supported Living Center (EPSSLC).

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, 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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary

responsibility. For this status review of El Paso SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, treatments and supports, and consent; Natalie Russo reviewed nursing care; Helen Badie reviewed medical services, dental services, and pharmacy and safe medication practices; Daphne Glindmeyer reviewed psychiatry services; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programming; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, record keeping, and quality assurance. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 July 19 through July 23, 2010, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. 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. 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.

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, 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 are required to provide the Monitoring Teams with such assessments 14 days prior to each onsite status review;

(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. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on). The Monitors are using this methodology in response to a request from the parties to

protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at EPSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring tour. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations.

The facility director, Tony Ochoa, set the tone for the week of the onsite tour. He was readily available, ensured that all requested information was obtained, and directed all of his staff to work cooperatively and openly with the monitoring team.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding more than 100 individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical, and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at EPSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist EPSSLC in meeting the many requirements of the Settlement Agreement.

Third, this was the first post-baseline tour of EPSSLC. These tours are called compliance tours and this is a report of the compliance tour, that is, of the facility's status in complying with the requirements of the Settlement Agreement.

In addition, the Settlement Agreement requires the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite tour. In the monitoring report, the Monitor is to describe and comment upon the self-assessment steps the facility undertook to assess compliance and the results of this self-assessment. At EPSSLC, the self-assessment consisted of two documents called the Plan of Improvement (POI) and Supplemental Plan of Improvement (SPOI). These were, however, submitted to the Monitor on the second day of the onsite tour. The POI

described the many actions the facility had taken, or planned to take regarding each provision of the Settlement Agreement. The SPOI described the facility's response to each of the recommendations in the baseline report. The Monitoring Panel and the parties have had a number of discussions regarding the POI and SPOI. As a result, a number of revisions and additions are going to be put in place for future POIs and SPOIs because in its current version, the documents did not provide the Monitor with sufficient detail regarding the facility's actions (e.g., number of cases reviewed, criterion used). Future monitoring reports will contain commentary from the monitoring team regarding the self-assessment processes for each of the provisions of the Settlement Agreement.

Fourth, a summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and an understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraints

- EPSSLC implemented restraint procedures that were, for the most part, in line with state policy and procedure. This provision, however, was rated as being in noncompliance due to further need for improvements in documentation, staff training, and implementing alternatives to restraint usage. Compliance with facility policy was difficult to assess by review of restraint documentation because a majority of the documentation was only partially completed with key information omitted from the Restraint Checklist forms. This also made it difficult for the facility to analyze restraint information to attempt reduction of restraints. There were behavior support plans in place for individuals with the highest number of restraints. There was concern from the monitoring team in regards to the lack of an interdisciplinary approach to addressing restraint reduction at the facility. It was not clear that all team members contributed information regarding what interventions had been tried to reduce restraints and had input regarding the effectiveness of those interventions.

Abuse, Neglect, and Incident Management

- EPSSLC had policies in place to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory. Overall, it was found that incidents were investigated quickly and consistently and the facility was quick to safeguard individuals from further harm. Some of the items in this provision were found to be in substantial compliance, others were found to be in noncompliance, and one item related to employee background checks was not rated at this time.

Quality Assurance

- An adequate, comprehensive quality enhancement plan did not exist at EPSSLC. Facility-wide data were not directed to the QE department. Regular reports were not completed by the QE department for use by senior management. EPSSLC was not in compliance with this provision. Even so, a number of QE-related activities were occurring at EPSSLC, including the observation and monitoring of various areas by QE program auditors, and by department staff. Moreover, the monitoring team's checklist tools were being sampled and tried out by the QE staff and many other managers around the facility. Important points regarding the monitoring team's checklist are included below in section E of this report.

Integrated Protections, Services, Treatment, and Support

- The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items required by this provision were either not developed or not yet implemented. As a result, noncompliance was the rating determined for most of the items in this provision. A sample of 17 Personal Support Plans (PSPs) was reviewed, and one annual Personal Support Team (PST) meeting and two interim PST meetings were observed during the onsite monitoring visit. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. Although much of this information was included in the plan and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision, nor did they focus on moving the individual into a less restrictive setting. In the PSP meeting observed, a majority of the time was spent reading over assessment information that was written in the draft plan. The individual and most of the meeting participants clearly lost interest in the discussion. A way to avoid this and facilitate a more productive meeting would be to send the draft plan out before the meeting and ask team members to review the assessment information prior to the meeting. Then, use meeting time to develop meaningful outcomes and supports.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. The facility had not identified a lead manager for this provision of the Settlement Agreement. Clinicians across the facility were not familiar with this provision. Moreover, a lack of integration of clinical services was evident at EPSSLC and this provision was found to be in noncompliance. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur. The facility, however, lacked direction in how to proceed regarding these provision items. This was due in part to (a) the recency of attention to this provision, (b) great confusion as to who was responsible for each component and the monitoring of each component of this provision, and (c) a plan of improvement that did not provide guidance or direction regarding specific actions to be taken.

At-Risk Individuals

- Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose of the identification of at-risk individuals. The state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals who were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern of the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other overwhelming concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk even with a plan in place. A Health Status Team (HST) was in place that met monthly. The team was chaired by the facility Medical Director. Observation of a HST meeting revealed that it was an interdisciplinary review of risk factors. The team's efficacy was inhibited by current state policies for assigning risk levels.

Psychiatric Care and Services

- Although psychiatry consultations were occurring, EPSSLC was found to be in noncompliance with all of the items in this provision of the Settlement Agreement. The psychiatry department at EPSSLC was in need of a strong leader. The clinic was not organized, nor were the physicians integrated into the overall treatment program at the facility. The physicians were not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, frequently made medication additions or adjustments in absence of data regarding specific target symptoms. Additionally, while staff from nursing and psychology attended psychiatry clinic, these clinic encounters were rapid and, per observation during this onsite monitoring tour, were not thorough with respect to a review of available records or interaction with the individual. Interviews with staff revealed that in most cases, the staff members were aware of the challenges and need for increased structure and integration with respect to psychiatry. Unfortunately, the facility was not able to retain sufficient psychiatric clinical consultation time due to a reported lack of providers available in the area.

Psychological Care and Services

- None of the items in this provision were found to be in substantial compliance with the Settlement Agreement. It is important to note, however, that there was progress toward compliance in several provision items. The most obvious need at EPSSLC relative to this provision was to ensure that the psychologists were competent in applied behavior analysis (ABA). Psychologists with training and experience in ABA are an essential component to achieving improvements in data collection and analysis, behavioral assessment, the quality and effectiveness of Positive Behavior Support Plans, and the establishment and management of essential behavioral systems.

Finally, the facility needs to ensure that psychological assessments are current and complete. EPSSLC's Plan of Improvement (POI) established long-term goals for compliance with this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will take some time for EPSSLC to make these changes, it may be useful for EPSSLC to also establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

Medical Care

- Overall, individuals received a wide variety of healthcare services. Policies and procedures were needed to guide the medical staff in the delivery of those services. EPSSLC was found to be in noncompliance with this provision of the Settlement Agreement because a number of areas of weakness existed in the medical services practice at the facility as indicated below in this section of the report. Integration of medical services will require that the medical director be involved in a vast array of programmatic activities outside of the usual clinical care responsibilities. The facility was planning for the transition to a new medical director and the additional of a nurse practitioner. The transition of patient care was ongoing and no definite caseloads had been established for either of the two new providers. The nurse practitioner completed the annual medical summaries and performed assessments during sick call and as needed. The staff physician was conducting sick call and gradually assuming a caseload.

Nursing Care

- EPSSLC's nursing staff members were caring, compassionate, and hard-working nurses. In general, record-keeping practices were improved from the baseline monitoring review. There was ample evidence that the individuals' physician was notified of significant changes in their health status and needs, and/or when they needed to be "put on the clinic list" and seen. There was also some evidence, in the shift reports, that nurses documented and also verbally communicated some changes in individuals' health status to each other during the change of shift report. During all observations of medication administration, nurses properly adhered to the accepted standards of medication administration; and they ensured individuals' privacy and dignity. As noted in EPSSLC's baseline review, however, the facility continued to implement a system of medication administration and reconciliation that led to medication errors and placed an overwhelming demand on the time and attention of staff. Problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks.

Pharmacy Services and Safe Medication Practices

- Overall, there were no grossly unsafe practices noted during this review. The hiring of a new pharmacy director, and the initiation of new procedures indicated that further improvements were likely, however, due to the recency of these changes, not all new practices were in place. Therefore this provision was found to be in noncompliance. The extent of medication errors in the facility, however, was unknown. The pharmacy had not been reporting errors to the Medication Error Review Committee (MERC)and physician errors appeared to go unreported. While personal accountability of every employee is important, it is likely that many of the errors being produced were being set-up by a medication dispensing system that was outdated and prone to errors.

Physical and Nutritional Management

- EPSSLC continued to use the PNMP Committee to review PNMPs during the month prior to the individual's annual PSP meeting and weight notifications. To a lesser degree, the meeting was used to review individuals who were at high risk in order to develop interventions to address PNM concerns. Documentation of the meetings had not been modified in order to more clearly track concerns and interventions through to resolution. As identified in the baseline review, this group continued to be too broad in scope and practice. They reviewed too large a number of individuals at one time such that it was not possible to effectively review all those at high risk for PNM concerns with sufficient frequency and intensity. It was also of concern that the facility's monitoring system had not previously recognized errors in physical and nutritional management, resulting in an absence of timely and effective correction and follow-up. Unfortunately, this was very consistent with the findings during the baseline review. Staffing resources had diminished since the baseline review, though it did not appear that the existing resources had been used as effectively as possible.

Physical and Occupational Therapy

- EPSSLC had a number of talented clinicians and the PTs, in particular, had taken a leading role in the improvement of supports and services provided. More active collaboration and clinical problem solving was evident in the process used to conduct assessments across disciplines including SLPs, though this was a relatively new, but critically important, practice. Evidence of OT contributions was reduced due to the loss of a strong clinician and at the time of this review, only one OTR was employed to conduct assessments, design interventions, and to supervise COTAs. Emerging focus on the identification of current functional skills and potentials for learning and additional skill acquisition was noted. Previous programs that had not been integrated into the PSP with specific objectives with data collection to measure progress had been converted to SPOs, and additional new training programs had been developed. These were strong first steps in the process of establishing well-defined assessments, interventions, and implementation strategies, though most of the changes had only been developed in the weeks just prior to this review.

Dental Services

- The facility was providing annual dental assessments. Actual treatment provided was limited and consisted primarily of cleaning. Relatively few restorative procedures were being done and x-rays were seldom done. Dental appointments were rarely completed without some sort of restraint. Overall, minimal services were being provided above hygiene, and restraints were being used frequently.

Communication

- Very limited progress in this area was evident since the previous review, though on a positive note, the facility had recently begun to contract with two strong clinicians with expertise related to AAC and communication. For most of this time, however, there continued to be only one clinician. Assessment formats and content related to communication had remained essentially unchanged until the month just prior to this onsite review. The sections for AAC did not reflect thorough and knowledgeable review of individual needs, and recommendations were rote and generally limited to continued use of the communication book and wallboards available in the homes. There did not appear to be a clear system of establishing priorities based on need for those who were nonverbal and those with communication-related behavior concerns. The two contract clinicians appeared to understand the process of functional design of these systems and they should play an important role in ensuring greater progress in this area during the next six months. Concerted effort should be directed toward continued recruitment of additional professional and technician level staff.

Habilitation, Training, Education, and Skill Acquisition Programs

- Overall, the skill acquisition plans at EPSSLC were not adequate to promote growth, development, and independence. The facility needs to better document that individual skill acquisition plans are chosen to address individual needs and preference. Additionally, the methodology used to teach individual SPOs was found to be inadequate to maximize learning. The facility, however, had made several improvements since the baseline monitoring review. EPSSLC improved its review of specific training objectives progress by adding graphed monthly summaries, and the facility scheduled a two day workshop to learn more about evidence-based techniques for teaching skills to individuals with developmental disabilities. The monitoring team was disappointed in the lack of progress noted in individual engagement. The level of individual engagement was low and approximately the same as that noted during the baseline monitoring review. Additionally, the individuals that were engaged were participating in the same routine activities (e.g., pegs in a board, puzzles, Legos) that they were involved in at the time of the baseline review. There was a new system for measuring individual engagement, and new schedules of interesting group activities posted in the cottages. Nevertheless, neither change was affecting the level or quality of engagement observed at the time of this onsite tour. The facility needs to make a better effort to ensure that changes made result in meaningful changes in individual engagement. There was not much evidence of skill acquisition in the community. Only one individual was

employed in the community at the time of the onsite tour, and there was no evidence that training in the community was developed to address individuals' needs for service or preferences.

Most Integrated Setting Practices

- Overall, EPSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and as are detailed below in this section of the report. Further, the monitoring team learned that updates to the DADS policy and procedures for most integrated setting practices were forthcoming. Overall, very few individuals were in the referral process at EPSSLC. A new and creative way for community providers to educate individuals, staff, and families was begun recently, but an evaluation of its effectiveness was needed. Further, An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. Some of the discussions appeared to be brief and/or done in a rote manner, however, others appeared to be individualized and to begin to refer to optimistic visions for the individual. The CLOIP was implemented for every individual reviewed. As indicated below, it should not be considered an assessment for placement, and further work will need to be done to create an assessment for each individual. Interestingly, comments on the CLOIP tool indicated that a number of individuals might be good candidates for community living, yet they were not referred for placement

Consent

- The state policy addressing guardianship was developed in January of 2010. The facility had not developed a policy regarding guardianship. The facility had just begun to address this provision at the time of the monitoring visit.

Recordkeeping and General Plan Implementation

- EPSSLC made progress towards meeting this provision of the Settlement Agreement. The new policy and record keeping practices were implemented in four of the 11 homes, representing approximately 43% of the individuals at the facility. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed and some sort of checklist of required/typical documents was needed to help ensure consistency across individuals. EPSSLC should ensure that record keeping is tied into the facility's quality enhancement program and that quality assurance activities occur related to record keeping. Moreover, it will be important for EPSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system. Management of the individual notebooks may become a challenge, especially regarding whether the

size of the notebooks competes with the goal of having information readily available to direct support professionals.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of EPSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team continues to look forward to continuing to work with DADS, DOJ, and EPSSLC.
Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management o DADS Policy #001: Use of Restraint o Restraint Checklist Form 4012008R o Administration of Chemical Restraint Form o EPSSLC Dental/Medical Sedation and Restraint Procedure, Revised 4/23/10 o EPSSLC Trend Analysis Report FY10 1st Quarter o EPSSLC List of Restraints 1/1/10 - 6/29/10 o Restraints by Individual per month from 6/09-6/10 o Restraint Reduction Meeting Minutes, 1/26/10 and 4/22/10 o Behavior Therapy Committee Meeting Minutes, 1/10 - 6/10 o List of individuals with Medical or Dental Desensitization Programs o List of injuries during restraint in the past six months o Training transcripts for the last three employees completing their orientation period o Training transcript for three experienced direct support professionals o List of individuals with safety plans o List of individuals at risk for challenging behaviors o Sample of Desensitization Programs for three individuals • Individual #95 - 5/10 • Individual #25 - 2/10 • Individual #195 - 5/10 o Sample of eight PSP addendums to review individual restraints • Individual #13 - 4/21/01 • Individual #13 - 4/27/10 • Individual #73 - 4/22/10 • Individual #74 - 4/23/10 • Individual #13 - 6/24/10 • Individual #104 - 4/14/10 • Individual #81 - 4/20/10 • Individual #8 - 4/20/10 o PSP for Individual #13 - 3/23/10 o Sample of BSPs for • Individual #13 - 4/1/10, • Individual #104 - 7/12/10

- Individual #8 - 12/19/09
- Individual #73 - 6/18/10
- Individual #104 - 5/19/10

- Safety Plan for Crisis Intervention (SPCI) for:
  - Individual #14, Individual #13, Individual #18, Individual #104, Individual #109, Individual #78, Individual #81
- Sample of Completed Restraint Checklist included in the following table:

Individual	Date	Restraint Type	Reason for Restraint
#104	7/9/10	Physical Hold	Aggression to staff/SIB
#104	7/3/10	Physical Hold/Chemical	SIB
#104	7/2/10	Chemical	Vision Exam
#104	6/29/10	Physical Hold/Chemical	Aggression to staff
#104	6/26/10	Chemical	Aggression to staff/SIB
#104	6/26/10	Physical Hold/Chemical	Aggression to staff/SIB
#104	4/27/10	Chemical	Aggression to staff/SIB
#73	6/25/10	Chemical	Aggression to staff
#73	5/28/10	Not documented	Medical
#73	5/13/10	Chemical	Aggression to staff/SIB
#73	4/20/10	Chemical	Aggression/property dest.
#73	4/1/10	Chemical	SIB/Property Destruction
#13	7/19/10	Physical Hold	Aggression to staff
#13	7/19/10	Physical Hold/Chemical	Aggression to staff
#13	4/24/10	Physical Hold	Aggression to staff & peers
#76	5/27/10	Chemical	Dental
#85	5/4/10	Chemical /Physical Hold	Dental
#116	5/12/10	Chemical	Vision Exam
#116	3/16/10	Chemical/Physical Hold	Dental
#88	5/6/10	Chemical	Unknown
#18	4/29/10	Chemical	Dental
#74	4/22/10	Physical Hold	SIB
#32	4/20/10	Chemical	Dental
#53	4/14/10	Chemical/Physical Hold	Dental
#53	3/18/10	Chemical/Physical Hold	Not Documented
#47	3/28/20	Chemical	Dental
#3	3/24/10	Chemical/Physical Hold	Dental
#29	3/18/10	Chemical/Physical Hold	Dental
#20	3/12/10	Chemical/Physical Hold	Dental
#38	4/27/10	Physical Hold	Aggression to staff/SIB
#38	3/8/10	Chemical/Physical Hold	Dental

#105	2/19/10	Chemical	Dental
#188	2/17/10	Chemical/Physical Hold	Dental
#175	2/4/10	Chemical/Physical Hold	Dental
#80	1/28/10	Chemical/Physical Hold	Dental

- Completed Face to Face Assessments for the following restraint incidents:
  - Individual #104 - 7/9/10
  - Individual #13 – 7/19/10
  - Individual #73 – 4/20/10

Interviews and Meetings Held:
- Informal interviews with various direct support professionals in homes and day programs
- Two Direct Support Professionals
- Valerie Grigg, Psychological Services Director
- Dr. Ken Wiant, Medical Director
- Gloria Loya, QMRP Coordinator

Observations Conducted:
- Observations at residences 506, 507, 508, 509, 510, 511, 512, 513, and Dorms A, B, and C
- Observations at the onsite workshop and prevocational program
- Incident Management Meeting 7/20/10 and 7/23/10
- Human Rights Committee meeting 7/21/10
- Mini PST meeting for Individual #13
- Health Status Team meeting 7/21/10

Facility Self-Assessment:

Please see the Executive Summary section of this report.

Summary of Monitor's Assessment:

EPSSLC implemented restraint procedures that were, for the most part, in line with state policy and procedure. This provision, however, was rated as being in noncompliance due to further need for improvements in documentation, staff training, and implementing alternatives to restraint usage.

Restraint data were provided to the monitoring team for the first three quarters of FY10. EPSSLC reported a total of 31 restraint incidents during the first quarter, 45 restraint incidents during the 2nd quarter, and 47 restraint incidents during the 3rd quarter. Restraint data indicated that there were 44 total emergency restraints in the first three quarters of FY09 and 80 emergency restraints in the first three quarters of FY10. Programmatic restraints increased from six in FY09 to 43 in FY10 during the same three quarters.

Data collected by the facility indicated a significant increase in the number of chemical restraints over the past three quarters. According to Restraint Reduction Committee meeting minutes and data analysis reports, this increase was attributed to the discontinuation of use of a restraint chair at the facility. The restraint chair had not been used at EPSSLC since September 2009. This would indicate that the facility had not focused on the reduction of restraints, but instead had replaced one type of restraint with another. It is not clear to the monitoring team why the number of restraints had increased even considering the substitution of chemical restraint for use of the restraint chair.

A list of all restraints used for behavior intervention by month provided to the monitoring team is summarized in the table below. It was noted that these numbers were not consistent with data provided to the Restraint Reduction Committee as listed in the above paragraph (the differences, however, were not great). The facility needs to ensure that all restraint incidents are included in data collection and facility trend analysis.

Month	# of Chemical	change from previous month	# of Physical	change from previous month
Jan 2010	4	n/a	4	n/a
Feb 2010	1	-3	5	+1
Mar 2010	5	+4	8	+3
April 2010	11	+6	5	-3
May 2010	13	+2	5	0
June 2010	18	+5	16	+11

Compliance with facility policy was difficult to assess by review of restraint documentation, since a majority of the documentation was only partially completed with key information omitted from the Restraint Checklist forms. This also made it difficult for the facility to analyze restraint information to attempt reduction of restraints. Details are summarized in the following sections of this report.

There were behavior support plans in place for individuals with the highest number of restraints. The facility did not consistently collect data on behavioral incidents and implementation of support strategies, so the efficacy of support plans was difficult to assess when trying to determine if restraints were used as a last resort measure after other least restrictive methods had been exhausted.

There was concern from the monitoring team in regards to the lack of an interdisciplinary approach to addressing restraint reduction at the facility. It was not clear that all team members contributed information regarding what interventions had been tried to reduce restraints and had input regarding the effectiveness of those interventions. Team members from all disciplines need to coordinate efforts to address behavioral issues, collect clear and consistent data, and develop behavioral support plans that address trends supported by data.

The facility had a Restraint Reduction Team that met quarterly. The team reviewed restraint trends but

	had not developed a plan to reduce the number of restraints at the facility. The Restraint Reduction Team should use data collected by the facility to make recommendations on reducing restraint in specific areas and develop outcomes and action plans for reducing restraints in those areas. Reduction efforts need to focus on any obvious trends identified in current data analysis and develop strategies that may prevent behavioral situations from escalating in specific situations. As discussed further in Section K of this report, behavior support plans should be based on data collected and analyzed in an interdisciplinary approach.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or 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.	The use of prone and supine restraint was prohibited by the policy. There was no evidence that prone or supine restraints were in use at the facility. Staff interviewed were aware of the mandates prohibiting the use of prone and supine restraints. Policies mandated that restraints may only be used in acute emergencies that placed the individual or others at serious threat of violence or injury and only after less restrictive measures had been determined to be ineffective or not feasible. The facility policy prohibited the use of restraint for disciplinary purposes, retaliation, and retribution, for the convenience of staff or other individuals, and as a substitute for effective treatment or habilitation. The policy outlined when and how restraints were to be used and described procedures that staff must follow regarding monitoring and documentation of restraint use. These policies were in line with the contents of this provision. A review of restraint documentation, however, did not support that the facility was in compliance with this provision item. Restraint incidents were not documented according to facility policy. A sample of 35 Restraint Checklists documenting restraint incidents from 1/28/10 to 7/19/10 was reviewed by the monitoring team. Eleven (31%) of the forms did not indicate a reason for the restraint. The section documenting interventions attempted to avoid restraint had only been completed on 12 (34%) of the 35 forms indicating that other interventions were attempted prior to restraint. It was not evident that restraint was considered a last resort strategy after all other least restrictive measures have been exhausted in most cases. Additionally, informal interviews with direct support staff at the facility revealed that staff did not generally feel that support strategies in the BSP were effective alternatives to implement in the place of restraints.	Noncompliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to	The facility policy mandated that restraints be terminated as quickly as possible and as soon as the individual was calm and no longer a danger to self or others.	Noncompliance

#	Provision	Assessment of Status	Compliance
	him/herself or others.	The monitoring team, however, was unable to verify compliance with this provision item from documentation provided during the review. Of the 35 Restraint Checklists reviewed, seven included physical restraint for crisis intervention. Three of the seven completed checklist did not indicate the time that the individual was released from restraints. The other four physical restraints lasted from three to 30 minutes in duration; all seven were followed with a chemical restraint. Eleven of the Restraint Checklist reviewed for dental procedures indicated that both physical and chemical restraints were applied. The duration of the physical hold was not noted on any of the eleven checklists. Documentation of physical restraints should all include the time that the hold was released and event code corresponding to the individual's behavior at the time of release.	
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.	As noted in section C1, it was not evident from restraint checklists that restraints used were the least restrictive intervention necessary to manage behaviors. Additionally, a review of restraint documentation did not support that staff had been adequately trained on documentation and follow-up to restraint incidents and, therefore, this provision item was found to be in noncompliance. Prevention and Management of Aggressive Behavior (PMAB) was used at all facilities across the state and was the specific training program identified in the state and facility policy. The policy described the types of restraints that were allowed to be used and listed restraint types that were specifically prohibited. There was no evidence that any prohibited restraints had been used during the period reviewed. Staff were required to complete initial training and were retrained at least annually on the use of restraints. This training included RES0105 Restraint: Prevention and Rules for Use at MR Facilities and Competency Based PMAB training. Training records were reviewed for the last three employees completing orientation. Each had completed RES0105 and PMAB training within 10 days of their hire date. Direct care professional staff indicated that campus auxiliary staff was available during evening and weekend hours and responded quickly to provide back up support if a behavioral crisis occurred. The facility announced a "code green" warning over the campus intercom system when a restraint was taking place. Several "code green" incidents were observed during the monitoring visit. Auxiliary direct support staff, nursing staff and psychology support staff responded quickly to provide assistance. These applications of restraint appeared to be done in a safe and correct manner. Direct support staff stated in informal interviews regarding response to restraint	Noncompliance

#	Provision	Assessment of Status	Compliance
		instances, that nursing staff were "quick to call for a shot to calm the individual down" in most instances. Observation, interviews, and documentation all indicated that chemical restraints were often used prior to attempting other less restrictive measures. Two of the 20 individuals reviewed, as part of the nursing sample, had been restrained with physical holds in the horizontal side-lying position for up to 30 minutes. Nursing notes briefly described the precipitants of the restraint, vital signs (when permitted by the individual), a brief word related to the mental status of the individual (e.g., "Agitation," "Hitting head"), and usually concluded with the phrase, "Will continue to monitor." For both individuals, the only documented intervention to address the individuals' behavior challenges prior to restraint use was the administration of a chemical restraint. Health-related precipitating events or triggers were identified for both individuals (e.g., seizure activity, noncompliance with medication administration, extreme temperature), however, management of these health events were not addressed via HMPs.	
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.	The facility policy stated that restraints may only be used for crisis intervention or medical reasons. There was no indication that restraints had been used at the facility other than for crisis intervention or medical reasons. Some work had been done at EPSSLC regarding the use of restraint for medical and dental care, however, as indicated below, more work needs to be done in order to meet the requirements of this provision item. The facility reported 15 instances of restraint used in the past six months for dental or medical appointments. Three of the individuals included in this sample did not have a desensitization plan in place according to information provided to the monitoring team. These three individuals included Individual #85, sedated for a dental appointment on 5/4/10; Individual #88, sedated for a dental appointment on 5/6/10; and Individual #53, a physical hold and sedation were used (the purpose of the appointment was unknown). Of the sample reviewed, 80% had a desensitization plan in place with strategies for reducing or eliminating the need for restraint during medical and/or dental procedures. A total of 55 individuals at EPSSLC had dental and/or medical desensitization plans in place. According to facility policy titled, Dental/Medical Sedation and Restraint dated 4/23/10, dental sedation was to be documented on a pre-and-post sedation checklist, and not on the Restraint Checklist form. All of the dental restraints reviewed were documented on a	Noncompliance

#	Provision	Assessment of Status	Compliance
		Restraint Checklist form. Additionally, the policy required a monthly trend analysis of dental and medical restraint and sedation would be reviewed at Restraint Reduction Committee meetings. Restraint Reduction Committee meetings did not indicate that this had occurred. Additionally, the monitoring team noted examples of medical restraint for behaviors that could, and should be monitored and treated by the psychology staff. For example, Individual #8 wore protective gloves to prevent self-injurious behavior (SIB), and Individual #84 wore a helmet that DCPs indicated was to prevent self-injury. Since these restraints were determined to be for medical reasons, they were not tracked or treated by the psychology department, and they should be. An example of how the psychology staff could be useful in cases involving SIB is illustrated by Individual #78. During the baseline review, Individual #78 was wearing a helmet during all waking hours, and staffed 2:1 to prevent self-injury. The psychology department developed a plan to fade the helmet and staff. During this onsite review, Individual #78 was restraint (helmet) free and staffing was reduced to 1:1.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject	The facility policy mandated monitoring of restraints by a health care professional within the guidelines of this provision. Restraints were to be monitored with a face-to-face assessment of individuals within 15 minutes of the application of any restraint. Staff were required to complete a Restraint Debriefing, Review, and Face-to-Face Assessment form for each incident of restraint applied for crisis intervention. The policy, additionally, addressed monitoring of individuals following restraints applied away from the facility with provisions of this agreement. Policy mandates met this provision of the Settlement Agreement. Restraint Checklists reviewed, however, did not support compliance with monitoring of restraints and, therefore, this provision item was rated as being in noncompliance. Review of six restraint checklists for monitoring and assessment revealed that monitoring and documenting of vital signs and mental status every 30 minutes from the start of the restraint only occurred in two of the six incidents. Documentation reflected that the facility policy regarding monitoring by a health care professional was not followed in four of the six incidents (66%). Details of those incidents are summarized below. • Restraint documentation for Individual #104 dated 7/9/10 indicated that the individual refused the first attempt by the nurse to check vital signs 25 minutes from the start of the restraint. No notations were made regarding the individual's mental status and no further attempts to monitor vital signs were documented.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Restraint documentation for Individual #13 dated 7/19/10 indicated that the individual refused assessment attempted by the nurse 30 minutes after the start of the restraint. No notations were made regarding the individual's mental status and no further attempts to monitor vital signs were documented. • Documentation for Individual #104 dated 6/26/10 indicated that the nurse did not assess the individual until 73 minutes after the start of the restraint. • Restraint documentation for Individual #13 dated 7/19/10 indicated that the individual refused assessment of vital signs by the nurse 20 minutes after the start of the restraint. The nurse documented that she would attempt to get vital signs later, but there was no documentation of a second attempt. The facility needs to insure that a health care professional does a face-to-face assessment of each individual as soon as possible following release from restraints. When an individual refuses assessment, the health care professional should attempt another assessment after allowing the individual time to calm.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with	The facility had a Restraint Checklist and Face-to-Face Assessment, Debriefing, and Review checklist for use when restraint was applied for crisis intervention. This form included a check for restraint related injuries. Facility policy addressed safety and supervision during restraint. This policy met the standards of this provision. Face-to-Face Assessment, Debriefing, and Review forms reviewed indicated one to one supervision, checks for injuries, and opportunities to exercise limbs, eat meals, drink fluids, and use the toilet, although, it was noted that these forms were not accurate with information on the Restraint Checklist. These forms appeared to be a routine exercise for staff rather than an accurate assessment of the restraint incident. For example: • The Face-to-Face Assessment form completed for Individual #13 regarding a restraint on 7/19/10 indicates a "yes" on the question "was the restraint face down/up physical or face down mechanical restraint?" The Restraint Checklist did not indicate that it was. The same assessment indicated that the Restraint Checklist was completed correctly. The time of release was not noted on the form and the form had not been signed by the staff implementing the restraint as required. The form also indicated that a nurse checked vital signs and status. Neither was documented on the Restraint Checklist. • The Face-to-Face Assessment form completed for Individual #104 regarding a restraint on 7/9/10 was incomplete. The restraint monitor omitted the questions regarding checks by a nurse, injuries from the restraint, opportunities to take medication, and eat a meal at mealtime. There was additional information missing from both the Face-to-Face Assessment and Restraint	Noncompliance

#	Provision	Assessment of Status	Compliance
	Appendix A.	Checklist from this incident. As noted throughout Section C of this report, the facility needs to provide updated training on documenting restraint incidents according to policy and ensure that restraints are properly monitored and individual's status is assessed both during and following restraint of any type.	
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:	The facility policy addressed this section of the Settlement Agreement requiring the Personal Support Team (PST) to develop and implement a Behavior Support Plan and a Safety Plan for Crisis Intervention for any individual placed in restraint, other than medical/dental restraint, more than three times in any thirty day period. According to a list provided to the monitoring team, there were seven individuals with safety plans in place at the time of the monitoring visit. Individual #57 had four documented physical restraints for aggression between 2/7/10 and 2/21/10. He did not have a safety plan in place, but did have a PBSP. His PST met the day following each of the restraint incidents to review the use of restraint. A PSP addendum documented each of the meetings. At each of the meetings, the team recommended continuing to follow his PBSP and review his medications. There did not appear to be discussion regarding revising his PBSP to try to develop more effective strategies for managing his aggression in a less restrictive manner. Informal interviews with direct care professionals and review of restraint documentation and Positive Behavior Support Plans revealed that staff did not have adequate strategies in place to ensure that restraints would only be used as a last resort intervention. The adequacy of Behavioral Assessments, Positive Behavioral Support Plans, and Crisis Intervention Plans is addressed elsewhere in this report. The facility will need to focus on behavioral assessments and recommendations to effectively reduce the number of restraints used for crisis intervention.	Noncompliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Data were not collected in enough detail to determine the cause of behavior provoking restraints. See section K for further recommendations regarding functional assessments of behavior.	Noncompliance
	(b) review possibly contributing environmental conditions;	Data and interviews with staff indicate that a majority of restraints occurred during or around mealtime and around 7:00 pm "which is very hectic, as it is when individuals have just finished eating, are showering, changing, doing chores, coming back from outings and family visits are in progress. All of this commotion and stimulation can act as a trigger to challenging behavior." There was no indication that the facility had considered modifying the environment or schedule for individuals with increased	Noncompliance

#	Provision	Assessment of Status	Compliance
		behavioral incidents at these times. This was also noted as a contributing factor during the baseline monitoring visit at EPSSLC. Observations at homes 506 and 512 confirmed that this is still a "hectic" time for individuals in those homes. Dining/common areas are overcrowded and prohibit a relaxed atmosphere for the individuals living there. It was noted during one observation at cottage 506, during a restraint incident, that there were 14 individuals and eight staff members present in the home. An additional four staff came to the home to assist with the restraint. There were three individuals with one to one staffing ratios in the home and one individual with two staff members assigned to him. There were an additional three staff members in the home. The overall atmosphere was tense, crowded, and chaotic, which could certainly lead to increase behavioral incidents. Although staff at the facility acknowledged the problem, little had been done to modify the environment.	
	(c) review or perform structural assessments of the behavior provoking restraints;	Data is not collected in enough detail to determine the cause of behavior provoking restraints. See section K for further recommendations regarding functional assessments of behavior.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Data were not collected in enough detail to determine the function of behavior provoking restraints. See section K for further recommendations regarding functional assessments of behavior.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint	See note C7 above. See section K for additional comments on PBSPs.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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	It was noted that consistent data was not being collected in regards to behavioral incidents and interventions, therefore, there was no evidence that treatment plans were relevant or that supports were carried out consistently across settings as written in current PBSPs. See section K for further recommendations in regards to implementing PBSPs.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	See note above.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The facility policy mandated that a review of each restraint, other than medical and dental restraint, would occur within three business days of the restraint based on the Restraint Checklist, the Restraint Debriefing Report, and, as applicable, the Chemical Restraint Consult form. The Restraint Checklist had a place to indicate review by the Restraint Monitor and Psychologist and a place to document the Unit Review date. As noted above, the restraints were reviewed by the restraint monitor on the Face-to-Face Assessment, Debriefing Form, but this assessment was not always completed accurately. Restraints that had occurred the previous day were reviewed at Daily Incident Management meetings observed during the review week. The team reviewed each restraint and discussed possible contributing factors to the behavior. Additionally, the PST was required to review restraints and document items C7.a – C7.g in a Personal Support Plan Addendum. PSP Addendums were written following restraint instances with a summary of the meeting discussion and any recommendations by the team. A PST meeting was observed during the monitoring visit to address restraint incidents for Individual #13. The team discussed possible reasons for an increase in behavioral incidents, but without consistent data collection, it was difficult for the team to make recommendations regarding the modification of behavioral support strategies. EPSSLC conducted quarterly restraint meetings. Review of restraints (across all categories) revealed an increasing trend in restraint at the facility, from an average of 9.6 restraints per month in the quarter ending 9/09, to an average of 21.6 restraints per month in the quarter ending 6/10.	Noncompliance

Recommendations:

1. Ensure that hierarchies of least restrictive measures are attempted prior to the administration of a chemical restraint.

2. Train all staff to accurately complete documentation on restraint incidents.

3. Complete behavioral assessments as often as needed to determine precipitating factors to restraint use and develop Positive Behavior Support Plans that offer direct care professionals a graduated range of less restrictive interventions to manage behaviors in the least restrictive manner.

4. Psychology staff should provide individual specific training to staff on strategies for behavioral intervention and request frequent feedback from staff on which strategies are effective. Plans should be reviewed and modified when strategies are not effective in deescalating aggressive or self-injurious behavior.

5. Ensure that all restraint incidents are included in data collection and facility trend analysis.

6. The Restraint Reduction Team should use data collected by the facility to make recommendations on reducing restraints in specific areas and develop outcomes and action plans for reducing restraints in those areas.

7. Continue to focus on developing desensitization programs for individuals currently using medical and dental restraints and develop written plans to support consistent implementation of desensitization efforts.

8. The facility needs to insure that a health care professional does a face- to- face assessment of each individual as soon as possible following release from restraints. When an individual refuses assessment, the health care professional should attempt another assessment after allowing the individual to calm down.

9. Develop a quality assurance process for all restraint documentation.

10. Incorporate into individuals' PSPs and/or HMPs, the health events/risks that trigger target behaviors and health-related interventions to reduce the likelihood that individuals' behavior will escalate and result in restraint.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o State Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management o Unusual Incident Report Coding and Reporting Matrix o EPSSLC Policy: Protection for Harm- Abuse, Neglect, and Exploitation, Revised 6/28/10 o EPSSLC Policy: Incident Management, Revised 6/28/10 o EPSSLC Policy: Level of Supervision, Revised 7/28/09 o Criminal Background Check and Registry Clearance Policy, Revised 11/21/08 o Investigation Training Curriculum o Documentation of Investigator Training for Virginia de la Vega and Mike Reed o Log of all Unusual Incidents 1/1/10 – 6/22/10 o Log of injuries resulting in fracture, suture, or Dermabond 12/1/09 - 6/23/10 o Log of Peer Caused Injuries 12/22/10 – 6/22/10 o Three most recent injury reports resulting from peer-to-peer aggression o Log of abuse and neglect allegations 1/1/10 – 6/23/10 o Training transcripts for the last three employees completing their orientation period o Training transcript for three tenured direct support professionals o Log of employees reassigned due to allegations 1/1/10 – 6/23/10 o Documentation of employee disciplinary action taken with regard to the last three confirmed incidents of abuse or neglect o Client Injury Report and Unit Initial Investigation Form for sample of five incidents of peer-to-peer aggression. o Log of employees reassigned due to A/N/E allegations 1/1/10 - 6/23/10 o EPSSLC Plan of Improvement o Daily Incident Management meeting minutes since 1/1/10 o Campus Administrator Report 7/19/10 - 7/20/10 o Sample of closed DFPS Investigative Reports • #53181190 7/8/10 Neglect Confirmed • #36837529 6/29/10 Neglect Confirmed • #36658610 6/14/10 Neglect Referred back to facility • #36502330 5/30/10 Neglect Unconfirmed • #36499929 5/29/10 Neglect Confirmed • #52527595 5/26/10 Neglect Unconfirmed • #52449330 5/21/10 Physical Abuse Unconfirmed • #52243030 5/10/10 Physical Abuse Unconfirmed • #36243031 5/9/10 Emotional/Verbal Abuse Unconfirmed

	#36146829 4/30/10 Neglect Unconfirmed #36105879 4/28/10 Neglect Unconfirmed #36097950 4/27/10 Physical Abuse Unconfirmed #51874670 4/19/20 Physical Abuse Inconclusive #35984310 4/18/10 Neglect Unconfirmed #35891269 4/9/10 Physical Abuse Unconfirmed #51653051 4/6/10 Neglect Unconfirmed #51533219 3/30/10 Physical Abuse Confirmed #35332430 2/23/20 Neglect Confirmed o Sample of Unusual Incident Reports (UIRs) #10-128 6/23/10 Serious Injury –Determined Cause #10-129 6/25/10 Non-Serious Injury of Undetermined Cause #10-124 6/14/10 Sexual Incident AP/Neglect #10-123 6/12/10 Non-Serious Injury of Determined Cause #10-108 5/9/10 Non-Serious Injury of Undetermined Cause #10-062 1/24/10 Death – Unusual Circumstances #10-074 2/17/10 Neglect #10-053 1/6/10 Death – Not under unusual circumstances #10-052 1/5/10 Neglect/Staff Training Issue #10-111 5/13/10 Non-Serious Injury Determined Cause Interviews and Meetings Held: o Informal interviews with various direct support staff in homes and day programs o Two Direct Support Professionals o Virginia De La Vega, Director of Quality Enhancement o Mike Reed, Facility Investigator o Mary Stohr, Risk Management and Safety Officer o Vivian Kaplan, DADS Regulatory Investigator o Jesus Sanchez, Program Auditor Observations Conducted: o Observations at residences 506, 507, 508, 509, 510, 511, 512, 513, and Dorms A, B, and C o Observations at the onsite workshop and prevocational program o Incident Management Meeting 7/20/10 and 7/23/10 o Human Rights Committee meeting 7/21/10 o Mini PST meeting for Individual #13 o Health Status Team meeting 7/21/10
	Facility Self-Assessment: Please see the Executive Summary section of this report.

	Summary of Monitor's Assessment: EPSSLC had policies in place to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS, local law enforcement, OIG, and DADS Regulatory. Overall, it was found that incidents were investigated quickly and consistently and the facility was quick to safeguard individuals from further harm. Some of the items in this provision were found to be in substantial compliance, others were found to be in noncompliance, and one item related to employee background checks was not rated at this time. The facility trended unusual incidents, including injuries, choking incidents, deaths, unauthorized departures, and allegations of abuse and neglect. Data was trended by individual, home, shift, day of the week, and injury/incident type. There were a total of 407 injuries reported during the third quarter of FY10 involving 106 individuals. Two of those injuries were serious injuries, accounting for less than 1% of the injuries; 62% were non-serious, but required treatment; and 38% required no treatment. Thirty of these injuries involved abuse or neglect allegations. The top causes of injuries were scratches, other, slips/trips/falls, and bumping into something. There were a total of 15 unusual incidents of all types reported during this same time period. Ten involved non-serious injuries, two were serious injuries with determined causes, one was a life-threatening emergency that occurred off campus, and two were classified as "other." The FY10 trend analysis for allegations of abuse and neglect during was reviewed. There were 77 cases of alleged abuse or neglect reported to DFPS during the 1st three quarters of FY10. This represented an increase of 40% from the same time period during FY09. The 77 cases reported involved a total of 124 allegations: 73 were allegations of neglect, 33 of physical abuse and 10 for verbal/emotional abuse. Of the 77 cases, six were confirmed as abuse or neglect; five were confirmed as neglect and one was confirmed as physical abuse. The facility attributed the increase in cases reported to DFPS, in part, to the fact that the Incident Management Team was reviewing incidents daily and reporting any where abuse and neglect could not be ruled out.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that	This provision item was found to be in substantial compliance. Assessment of this item required review of policies and an examination of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	implementation of those policies. The state policy was labeled "Protection from Harm-Abuse, Neglect, and Incident Management." It was numbered 002.1, and was dated 11/6/09. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and staff reporting. The facility had policies in place titled Protection for Harm- Abuse, Neglect, and Exploitation, Revised 6/28/10 and Incident Management, Revised 6/28/10. The policy on Incident Management indicated that EPSSLC would have a commitment of zero tolerance for harm or threat of harm to individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in each facility visited and all staff interviewed were able to relay this information.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with 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.	The facility policy specified reporting requirements for all serious incidents and was in line with this provision. The facility policy included a section on incident reporting responsibilities for determining to whom incidents should be reported, and within what time frame. The facility utilized a standardized reporting form for all serious injuries and incidents. Unusual Incident Reports documented notification to the Facility Director, After-Hours Duty Officer, DFPS, Law Enforcement, State Office, OIG, and DADS Regulatory. A sample of 10 investigative reports were reviewed and indicated that notifications were made as required with one exception. UIR 10-108 did not indicate that the Facility Director had been notified. The time of DFPS notification was also not indicated on the report. Policies mandated that all incidences of suspected abuse, neglect, or exploitation were to be reported to DFPS within one hour. A review of investigation documentation confirmed that the facility was generally in compliance with this mandate, although, there were exceptions as noted in D.2.d below. There were posters at each facility site that provided basic instructions on intervening to	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		stop abuse, as well as reporting abuse. The 1-800 number to call to report suspected abuse was posted on bulletin boards and near phones around the facility.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The policy mandated immediate action and reporting of all allegations of abuse and neglect. Initial staff in-service training included training on recognizing and reporting incidents of abuse and neglect (Course ABU0100) that was to be provided upon initial hire and annually for tenured staff. Staff interviews confirmed that staff were aware of the mandate to immediately protect the victim from further harm. Further, facility staff appeared to take immediate and appropriate action to protect individuals involved. Observation of facility Incident Management Meetings confirmed that participants discussed incidents and injuries and made recommendations to further protect the individual if warranted by reviewing preliminary investigative reviews, removing alleged perpetrators, increasing staffing ratios, or requesting other additional supports as needed. The facility had a policy addressing the reassigning of alleged perpetrators. A log provided to the monitoring team indicated that alleged perpetrators were routinely reassigned during investigations. A review of Incident Management meeting minutes indicated that the committee tracked the reassignment of alleged perpetrators until a case was resolved. According to the Facility Investigator, staff were not returned to regular duties until DFPS notified the facility that the allegations were not confirmed. A log of abuse and neglect allegations revealed that the perpetrator in the one confirmed case of physical abuse was dismissed. In the four cases of confirmed neglect with a known perpetrator, employees involved were either suspended or received performance counseling.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation. Documentation of training was kept by the facility and a small sample of seven staff records was reviewed. Training transcripts for the employees reviewed showed that all had received required training on abuse and neglect within the past year. During interviews, all employees were able to give accurate examples of abuse and neglect and verbalized their responsibility for reporting such incidents. A larger sample of training records will be reviewed for compliance of this provision item during future monitoring visits.	Substantial Compliance
	(d) Notification of all staff when commencing employment and	The policy addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. In all facility buildings toured during the review, posters	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	stating the obligations of mandatory reporters were posted in common areas. The facility policy stated that, "each employee, agent, or contractor who suspects or becomes aware that an individual has been abused, neglected, or exploited shall make a verbal report to DFPS immediately, within one (1) hours after suspicion or after learning of the incident." Even so, a review of investigations at the facility revealed that staff suspecting abuse, neglect, or exploitation did not always report to DFPS as required. For example: • In DFPS investigations #366586 dated 6/14/10, a direct support professional reported possible neglect to her supervisor around 9:10 AM. The cottage supervisor immediately reported the incident to the facility investigator. DFPS was not notified until 11:56 AM that day. State policy required that staff directly report suspected abuse or neglect to DFPS within one hour if that staff person suspects abuse or neglect. The facility should address reporting mandates with any employees failing to report suspected abuse or neglect within required time frames.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. Clear reporting information was posted in each building in the facility. A review of abuse and neglect investigations indicated that at least some of the individual's family members were aware of reporting procedures and had reported suspected abuse and neglect incidents to DFPS.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	All facility buildings toured had posters with a statement of individuals' rights posted in common areas. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read.	Substantial Compliance
	(g) Procedures for referring, as	The facility policy included procedures for referring appropriate allegations of abuse and	Substantial

#	Provision	Assessment of Status	Compliance
	appropriate, allegations of abuse and/or neglect to law enforcement.	neglect to law enforcement. The facility Lead Investigator was assigned to coordinate investigations with law enforcement and OIG Investigators. The following are two examples in which law enforcement was notified by DFPS. In DFPS case # 35752790, involving alleged physical abuse by a staff person, documentation shows that OIG was notified by DFPS and completed an investigation. In DFPS case #36459889, regarding a fractured finger resulting from a fall, law enforcement was notified by DFPS, the results of that report are unknown.	Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Policies prohibited retaliatory action for reports of an allegation of abuse or neglect. The policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and mistreatment should be reported. No cases of retaliatory action or allegations of retaliatory action were found by the monitoring team.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Although there was no evidence of semi-annual audits related to significant injuries, the facility kept a log of all injuries and whether or not they were reported for investigation. A sample of 10 UIRs were reviewed, five of those were for injuries. Injuries were investigated thoroughly and consistently to try to determine if abuse or neglect was a contributing factor. Injuries were reported on at the Daily Incident Management meeting. At meetings observed during the monitoring visit, incident management team members questioned injury reports and requested more information regarding several injuries. The team spent a majority of the meeting discussing non-serious injuries and making recommendations to prevent similar injuries. A review of documentation of serious injuries supported that they were routinely reported for investigation. Investigative reports for serious injuries were thoroughly and consistently investigated. According to the facility investigators, all serious injuries were investigated by the facility investigators and then referred to DFPS or DADS as required.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state policy addressed the conduct of investigations and qualifications of investigators. The policy stated that all investigators who were responsible for completing all or part of the Unusual Incident Report must complete the course, Comprehensive Investigator Training (CIT0100) within one month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report. Additionally, the Incident Management Coordinator and Primary Investigator(s) must complete the Labor Relations Alternatives (LRA) Fundamentals of Investigations training (INV0100) within six months of employment. Training documentation for two facility investigators was provided to the monitoring team. This included Comprehensive Investigator Training for Mike Reed, Lead Investigator, and Virginia De La Vega, Director of Quality Enhancement. According to interviews, Campus Coordinators and Program Auditors had also received this training so that they could begin preliminary investigations in the event the facility lead investigator was not accessible. Having numerous trained investigators on campus ensured that investigations could begin promptly. The facility policy also stated that the investigator would not be in the direct line of supervision of the alleged perpetrator and must be trained in working with people with intellectual disabilities. There was no evidence that this was not the case.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff were required to cooperate with DFPS and law enforcement agencies in conducting investigations. An interview with the facility investigator, and review of a sample of completed investigations indicated investigations were a cooperative effort with DFPS investigators. The lead facility investigator was interviewed and was able to describe incident types and the process for reporting to DFPS, OIG, local law enforcement, and DADS regulatory. A DADS Regulatory investigator was onsite during the review week and confirmed that the facility worked cooperatively with DADS Regulatory.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	It was evident from a review of documentation that the facility investigators completed preliminary steps to ensure the safety of the individual (e.g., medical evaluations and removing APs), and then allowed appropriate entities to complete investigations as necessary. The facility investigator stated that the facility had a good working relationship with local law enforcement agencies and OIG and worked cooperatively with them.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The facility policy described procedures for safeguarding evidence in the event of a serious incident. Some DFPS investigations were not completed in a timely manner (see below) leading to questions of whether or not investigators were able to gather all evidence while it was still available.	Noncompliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The policy addressed timelines for investigations. The state policy required that investigations commence within 24 hours and allowed for investigations to be completed within 14 days (10 days after 6/1/10). While DFPS policy allows for the initial facility notification of an allegation to be the start of an investigation, the monitoring team views the first attempt to gather information at the facility as a starting point for the investigation. Several concerns that arise from this practice include, the opportunity to tamper with evidence, the opportunity for collaboration between perpetrators and staff, and the victim's inability to recall events after time has lapsed. Therefore, while investigations may have met DFPS requirements, some did not meet requirements of the Settlement Agreement to commence the investigation within 24 hours. Furthermore, DFPS classified abuse and neglect cases as Priority I or II, allowing additional time for face-to-face contact in a Priority II case. The Settlement Agreement uses the terminology serious incident, all cases of suspected abuse or neglect are considered a serious incident by the monitoring team. Most DFPS investigations in the sample began within 24 hours of the allegation and were completed within the required timeframe, however, the following are examples where initial attempts to gather information did not commence within 24 hours of notification: • DFPS investigation #36401949 was reported on 5/21/10 at 12:07 PM. The initial face-to-face investigation did not occur until 5/24/10 at 11:13 AM and the investigation took 18 days to complete. There was no indication that an extension had been filed. The five-day status report was dated 5/8/10 prior to the initial notification. • In DFPS investigation #36459889, a neglect allegation was reported on 5/26/10	Noncompliance

#	Provision	Assessment of Status	Compliance
		at 2:15 PM and the Initial Face-to-Face Investigation did not begin until 5/28/10 at 10:30 AM, not meeting the requirement to commence within 24 hours. • In DFPS investigation #36097950, a physical abuse allegation was reported to DFPS on 4/27/10 at 12:59 PM. Investigation did not begin until 4/29/10 at 1:44 PM. • In DFPS investigation #36105879, an allegation of neglect was reported to DFPS on 4/28/10 at 3:41 AM. The investigation did not begin until 4/30/20 at 4:08 PM. DFPS reports included a comprehensive summary of the investigation. Some of the investigations included recommendations for follow up action by the facility based on information gathered during the review. It was noted that mortality reviews were not completed in a timely manner. Reviews had just been completed up at the time of the onsite visit for two individuals who were residing at EPSSLC at the time of their deaths in January 2010. The clinical review for Individual #22 was not completed until 6/19/10 and the administrative review was dated 7/13/10. Corrective action recommended in the review had still not been implemented.	
	(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	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. Investigation files were consistently compiled in a clear and easy to follow format. The sample of DFPS investigative reports all contained the elements listed in this provision of the Settlement Agreement except for the previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency in all cases. In DFPS case #52243030, the investigator noted that the individual involved had a history of making false allegations, though no other previous investigations were listed in the report to substantiate this. Facility investigative reports were clearly and consistently written and contained all elements listed in this provision in a standardized format.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.		
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	A review of unusual incident investigations completed by the facility investigators indicated that final investigations were reviewed by the Facility Director and findings were reported during Daily Incident Management Meeting. Review by the Facility Director did not always occur in a timely manner. For example: • UIR 10-128 was reviewed by the facility director 18 days after completion of the investigation. • UIR 10-129 was reviewed by the facility director 10 days after completion of the investigation. • UIR 10-123 was reviewed by the facility director 12 days after completion of the investigation. DFPS investigation reports were signed by the investigator and DFPS supervisory staff. Findings were reviewed during the Daily Incident Management meeting.	Noncompliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A sample of Unusual Incident Investigation forms was reviewed by the monitoring team. Each written report was written in a clear and consistent manner. Reports included an in depth summary of investigative procedures, relevant history, personal information about the individual, a list of immediate corrective actions to be taken, and an analysis of findings and recommendations for remedial action to be taken.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and	It was evident that the facility followed up on individual incidents by immediately removing alleged perpetrators from contact with individuals, taking disciplinary action when warranted, and holding PST meetings to review incidents and take corrective action as needed. Action taken in each case was documented by the facility on the Unusual Incident Investigation form. Corrective action was discussed and reviewed at daily incident management meetings. Unusual Incident Reports included a list of immediate corrective action taken and a list of recommendations for current/future	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	track and document such actions and the corresponding outcomes.	actions. Both areas of the report were completed for each case and relevant recommendations were made by the investigator. The facility maintained a log of APs reassigned during investigations. APs were assigned to positions within the facility that required no contact with individuals served at the facility during investigations. They were not released to return to their previous position until DFPS completed their investigation. A review of Unusual Incident Reports, level of supervision logs and PSP addendums documented that there was usually a level of supervision increase, immediately and at least temporarily, for individuals involved in any type of unusual incident. The increased level of supervision remained in place until either the PST or the incident management committee recommended a return to routine supervision.	
	(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 records from the past year confirmed that files were maintained and were easily accessible for review. When investigation files were requested during the review, they were immediately available from the facility investigator. One DFPS investigation, however, did not include a log of previous incidents for the individual or perpetrator, though the report concluded that the individual had a history of making false allegations..	Noncompliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. Incidents and allegations were trended by individual, home, location, date and time, staff involved, cause, incident type and results of any related investigations.	Substantial Compliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a	The Monitoring Panel has had discussions with the state regarding how this provision of the Settlement Agreement will be assessed. This is necessary due to the confidentiality of the information, and the limited documentation that the state is allowed to maintain	Not Rated

#	Provision	Assessment of Status	Compliance
	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.	regarding the findings of the background checks. To address this, the state will provide the Monitoring Teams with names of staff responsible for the process, so that they can be interviewed, and spreadsheets for each Facility to allow reviews to be conducted to ensure that all staff currently employed have had the necessary checks completed. Until such information is made available, this indicator will not be rated.	

Recommendations:

1. Ensure that all employees know that any witnessed or suspected incidents of abuse, neglect, or exploitation must be reported to DFPS within one hour.

2. The facility director or designee should review all investigations as soon as possible after completion and make recommendations if warranted.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o EPSSLC Policy and Procedure, Quality Enhancement, reviewed 6/28/10 (identical to state policy) o EPSSLC Review Processes, Quality Assurance Process, dated 6/28/10 o Organizational chart, dated 6/10 o List of meetings scheduled for the week of 7/19/10 o EPSSLC description of the purpose of PIC o PIC monthly meeting notes and agendas, December 2009 through April 2010, except March 2010 o PIC meeting minutes from observed meeting, 7/22/10 o PET monthly meeting notes and agendas, January 2010 through July 2010 o PIT monthly meeting notes and agendas, February 2010 through May 2010 o EPSSLC POI, 6/10, submitted to monitoring team 7/20/10 o EPSSLC DADS ICFMR annual survey, 6/10/10 o EPSSLC Quarterly Trend Analysis for unusual incidents, abuse and neglect allegations, injuries, and restraints, through 5/31/10 o Variety of tools used by program auditors o Variety of tools used by other departments that were not used by, managed by, or known to the QE department o Report indicating scores of program auditors, called "Reliability Tool" o Databases of a number of different measures, such as community excursions o Documentation of staff training on root cause analysis o Notes for facilitators of self-advocacy meeting Interviews and Meetings Held: o Tony Ochoa Facility Director o Virginia de la Vega, Director of Quality Enhancement o Petra Robledo, Settlement Agreement Coordinator o QE Department staff: Jesus Sanchez, Elaine Lichter, Victor Quiroz o Jeff Moody, Residential Unit Director o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. Observations Conducted: o Many residences, day program, and vocational program o PIC Meeting, 7/22/10

	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: EPSSLC was not in compliance with this provision. An adequate, comprehensive quality enhancement plan did not exist. Facility-wide data were not directed to the QE department. Regular reports were not completed by the QE department for use by senior management. Even so, a number of QE-related activities were occurring at EPSSLC, including the observation and monitoring of various areas by QE program auditors, and by department staff. Moreover, the monitoring team's checklist tools were being sampled and tried out by the QE staff and many other managers around the facility. A self-advocacy group had recently been re-initiated. It is expected that the quality enhancement program will develop and mature over the next few years at EPSSLC. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the QE department's data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report. Other comments are detailed below in this section of the report. The monitoring team looks forward to continued development of EPSSLC's quality assurance program.

#	Provision	Assessment of Status	Compliance
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.	Based upon a review of documents, interviews with facility staff, and observations at the facility, EPSSLC was not in compliance with this provision item. A review of this section of the Settlement Agreement required the monitoring team to look at policy, processes, and outcomes related to quality assurance activities at EPSSLC (these are referred to as quality enhancement (QE) in this report). A policy was developed by the state DADS regarding quality assurance titled "Quality Enhancement." It was labeled policy #003 and was dated 11/13/09. The facility had adopted this policy in full. The policy called for a quality assurance system that, if implemented, would meet the requirements of this provision of the Settlement Agreement. The policy had a number of addenda and forms that were to be used for the Quality Enhancement plan, corrective action plans, tracking of these plans, and operation of the performance	Noncompliance

#	Provision	Assessment of Status	Compliance
		improvement council. EPSSLC, however, was not implementing or following the components of this policy at the time of the onsite monitoring tour. It did not have a comprehensive, organized, or systematic quality enhancement process in place. There were, however, a number of quality enhancement-related activities going on at the facility. Nevertheless, as a result of the absence of any quality assurance system or quality enhancement plan, EPSSLC was not meeting the requirement of this provision, that is, that data be tracked to identify trends across, among, within, and/or regarding, program areas, living units, areas of care, staff, and/or individuals. Further, there was no trending regarding overall protections, supports, and services as required by this Settlement Agreement provision. The monitoring team expects to see a more formal and comprehensive quality assurance and quality enhancement program initiated and in place at EPSSLC when it returns for the next onsite tour. <u>Policies</u> The Director of Quality Enhancement told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. It was copied in whole and presented as the facility's policy, along with a signature from the facility director. At EPSSLC, there were no policies or processes related to quality enhancement that were specific to the facility or that referred to the state policy. EPSSLC should consider whether the development of facility policies for QE might be helpful to the overall operation of a QE program at the facility. If so, EPSSLC will need to ensure that its policies are in line with any state policies. Further, any facility policies related to QE should be reviewed and approved by DADS central office. <u>Quality Enhancement Plan</u> The DADS policy required the development and implementation of a quality enhancement plan (QE Plan). An adequate QE plan did not exist at EPSSLC. In general, a QE plan should indicate all areas that are to be audited, the tools to be used, the frequency of audits, and the staff who are responsible for these audits. It should also describe the type of report(s) to be generated. The QE plan should incorporate all areas of quality enhancement, data collection, and information related to quality across the entire facility. As noted below in this section of the report, numerous activities were going on at the facility (e.g., data collection, observation and feedback), however, most of it was not a part of the QE program (or	

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		even known to the QE director and staff). The QE department should play a role as a repository for all of these activities at the facility so that the information can be synthesized, summarized, analyzed, and presented to senior management in a manner that is useful for decision making and efficient and effective management of all services and supports at EPSSLC. The QE director submitted a document titled "EPSSLC Review Processes, Quality Assurance Process," dated 6/28/10, to the monitoring team. She reported that this was the facility's QE plan, but it was woefully inadequate, that is, it did not look at comprehensive quality assurance processes, goals, outcomes, nor did it align with the state policy. It looked similar, if not identical, to a document observed at another facility and was copied here. QE Department Virginia de la Vega was the director of the QE department. She was hired for this role at EPSSLC five years ago. Prior to that, she was an ICFMR surveyor, and a vocational rehabilitation counselor. She supervised the QE department program auditors and data analyst (four FTEs), client records staff (three FTEs), the health status team coordinator (one FTE), and safety and investigations (three FTEs). The auditors were added to the department on 11/1/09. This appeared to the monitoring team to be a reasonable set of responsibilities for this department. Facility senior management, however, should ensure that incident management and investigation responsibilities do not compete with the director's ability to attend to the important needs of quality enhancement, as described throughout this section of the report. The QE director reported that there was a good working relationship between the QE department and other departments at EPSSLC. She noted that the facility director was available and accessible if she should need him for support or direction. Petra Robledo, the Settlement Agreement Coordinator, also played a role in quality enhancement activities. She was responsible for document management for the monitoring team as well as overseeing the PIC, PET, and PIT meetings. It appeared, however, that data and information from these meetings were not coordinated in any way with the QE department. The facility, with support from senior administration, should ensure that the work of the Settlement Agreement Coordinator is incorporated into the QE activities at EPSSLC. Other types of professional development for quality enhancement staff should be	

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		considered, including, for example, quality assurance in the field of developmental disabilities and those with dual diagnoses. Further, DADS should consider ways for program auditors across the state to interact with, and learn from, each other. The monitoring team was pleased to see that approximately two dozen management and QE staff attended a recent all day training on root cause analysis. <u>QE Activities and Indicators</u> A number of QE activities were occurring at EPSSLC. The three program auditors and the data analyst were involved in many different activities. The monitoring team had the opportunity to meet with two of the three program auditors and with the data analyst. This was an energetic group of employees who appeared to be committed to operating in a professional manner and in providing a service that would be valuable to the facility. Many performance indicators (i.e., measures) existed at EPSSLC and, again, it was good to see that the facility was engaged in implementing these measures. The data collected may prove useful to the facility. Nevertheless, as noted above, the choice of these indicators, their design, and their management were not done in any comprehensive, thoughtful, or systematic manner. For example, a number of tools appeared to have been developed at Lubbock SSLC in order to address many areas of the Settlement Agreement. Some of these may be valuable and were being used at EPSSLC, but there had been no consideration of how these tools might or might not fit into an overall process to assess quality and monitor the facility's progress towards meeting the provisions of the Settlement Agreement. Further, there was no special attention paid to ensuring that quality assurance activities were occurring for the four specific provisions of the Settlement Agreement that called for quality assurance or quality improvement activities (F2g, L3, T1f, and V3). In addition, there was no special attention paid to the Health Care Guidelines or Dental Guidelines by the QE department. Below, are listed a number of the indicators being measured and/or collected and some of the tools being used by the QE department. • QSO tool to assess PSPs (note, however, that use of this tool was discontinued at other facilities due to the length of time required to complete the tool given the relative usefulness of the information it produced) • Follow up monitoring of EPSSLC investigations • Restraint monitoring tools from Lubbock SSLC called restraint analysis and multiple restraint • PBSP analysis using a Lubbock SSLC tool called, "J and K" • Level of supervision using a Lubbock SSLC tool that involved direct observation,	

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		interview of staff, and a review of the LOS card • Individual's living environment assessment tool • Monitoring of the active pursuit of guardianship • Tracking of consents and status using a tool from Lubbock SSLC • Some of the monitoring team's monitoring tools (EPSSLC referred to these as verification audit tools) • Death reviews • Review of high risk individuals • Check on inter-rater agreement of some of the nursing tools. • Individual weights: BMI, weight and height • Number of excursions and where visited (i.e., outings); by person, location and number persons • Individuals participating in religious activities • Admissions • Deaths • Discharges • Hospitalizations • Individuals treated for dental care at EPSSLC since May 2010 (in new clinic) • List of individuals who receive pre-treatment sedation The monitoring team was pleased to see that EPSSLC had made some efforts to incorporate the contents of many of the tools used by members of the monitoring team. As discussed during the onsite tour, please remember that these tools were designed for use by the monitoring team and, therefore, many items will need to be adapted for use by facility staff. Additional points are listed below. • The monitoring tools do not include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who did not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of monitoring team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who had more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. • There was some discussion that these tools would be used to generate a cumulative score with regard to compliance. The items on the tools have not	

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		been weighted, but would need to be if they were going to be used in this manner. • Some of the indicators on the tool were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. • At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet likely would assist in this process. The monitoring team also found that other departments were collecting data, conducting monitoring, and summarizing data. These, however, were not submitted to the QE department, and in most cases, surprisingly, the QE department was not even aware that these activities were occurring. The facility should ensure that all relevant data be submitted to the QE department as indicated above in this section of the report. Below, are listed some of these other indicators being managed by other departments at EPSSLC. • A variety of data collected by the medical department (e.g., incidence of osteoporosis) • A variety of data collected and charted by the by nursing department (e.g., otitis media, MRSA, UTIs) • Enteral G-tube management • Medication administration • PNMP implementation • Meal observations • Lifting and Transfers • PSP meeting contents • HST coordinator audits of actions called for during HST meetings In addition, a large amount of information and data appeared to be presented in the PIT meetings (see below in section E2) based upon a review of the minutes of the meetings, and to a lesser extent in the PIC and PET meetings. The QE department did not appear to play any role in the organization or summarization of any of these data. The DADS policy called for "an integrated, reliable and valid data information system that compiles relevant individual and organizational data…" (page 2); the facility to "review	

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		and monitor the integrity and validity of the data…" (page 6); and that "data must be tracked 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." (page 7). The QE system at EPSSLC was not meeting this requirement, although it was encouraging to see that some activities related to inter-rater reliability had been initiated. These clear directives from the policy require that the QE department: • Ensure validity of the items in each tool (i.e., whether the tools actually measure what it is they are purporting to measure). This requires an examination of the definitions that the auditors used to determine if the item was present. - Experts in each discipline area should be involved in this process, both at the facility level, and at the state level (i.e., central office discipline heads). - Evidence needs to be provided that stakeholders agree that the indicators are important. - Detailed definitions are needed for auditors to determine the presence or absence of the indicator. o There was no evidence that any work had been done at EPSSLC to address the validity of the indicators and measures. • Ensure the tools are reliable; that is, that there is agreement across auditors, that unintentional bias by auditors is reduced, and that observer drift does not occur (a change, over time, in what is accepted to indicate presence of the indicator). o There was some activity related to inter-rater agreement occurring at EPSSLC. This had begun with six of the nursing checklists and the intention was to expand to 12 checklists. Both the program auditor (in this case, the QE nurse) and program nurses completed a number of monitoring tools. Then their completed checklists were compared. During the onsite tour, the monitoring team spoke at length with members of the QE department regarding ways in which they should (a) talk with nursing staff regarding any disagreements on the two forms, and (b) calculate a metric to describe the level of agreement between the two raters. EPSSLC also collected and reported data on a number of areas, as was required by the DADS central office, called the Trend Analysis Report. Again, these data were not incorporated in any useful manner or into any type of overall facility QE plan or report. Data were presented to the monitoring team for the period of September 2008 through May 2010. These measures were unusual incidents, abuse and neglect allegations, injuries, and restraint usage. Data back to September 2008 were presented in a table	

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		format, the current quarter's data were presented as bar graphs, and some brief narratives were provided. Only one line graph was included, but the data for FY09 did not match the data on the table. Satisfaction surveys were recommended in the EPSSLC baseline monitoring report. Satisfaction surveys had not yet been conducted at the time of this onsite tour at EPSSLC. Satisfaction surveys are an important part of any quality enhancement program and usually include an assessment of the satisfaction of individuals, their families and LARs, staff, and affiliated providers (e.g., local hospital, community physicians, community employers). These groups are surveyed to assess their satisfaction across a range of areas, some broad, some very specific. To further support the need for these type of surveys, the policy on page 3 notes that the QE program should "...assess individuals satisfaction with services and supports." A self-advocacy group can provide one way of assessing, or learning about, individual satisfaction, opinions, and suggestions. The monitoring team was pleased to learn about the recent re-initiation of this group at EPSSLC. Based upon a review of notes regarding the self-advocacy group, it appeared that nine individuals attended the meeting and that a number of relevant topics were discussed, such as what it means to be an advocate, the meaning of self-determination, the "Right for the Day" (to be free from abuse and neglect), and ways in which individuals can control their own lives. The monitoring team looks forward to the development of the self-advocacy group and to attending their meeting during the next onsite tour. In summary, and to reiterate, numerous QE activities were occurring at EPSSLC even though a coordinated, comprehensive QE plan was not in place. The absence of a QE plan, however, resulted in the activities being fragmented, isolated, and, to a large extent, appearing to be random in their selection, design, application, and usefulness. QE-Related Committees The DADS policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation) at EPSSLC. The policy required a program improvement committee; this was in place at EPSSLC and is described in section E2 below. The facility held a daily Incident Management Meeting. This was a daily meeting during which senior management reviewed the previous day's incidents, emergency	

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		restrictions, restraints, injuries, and aggression between individuals. Although this meeting was not a QE meeting, it might be used by facility administration (in addition to the PIC described in section E2 below) as a way to incorporate QE activities into the daily operation of the facility (also see section D of this report). QE Reports The DADS policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	This provision item required the facility to analyze the data collected by the QE processes that are implemented at the facility. Based upon a review of documents, interviews with facility staff, and observations at the facility, EPSSLC was not in compliance with this provision item. A quality assurance report did not exist and was not in the process of being developed or created. A quality assurance report should include data, line graphs, and narrative, at a minimum. EPSSLC did not have any type of quality assurance report other than the state required trend analysis of restraint usage, injuries, unusual incidents, and allegations of abuse or neglect. As indicated above, little analysis of data occurred at EPSSLC and should, therefore, be one of the facility's priorities as it moves forward in developing an active and functional QE system. During the time of the onsite monitoring tour, the facility was not summarizing or analyzing the data collected by the program auditors in a way that could be useful and meaningful to facility management (other than perhaps the summaries provided in the statewide Trend Analysis Report). If anything of importance was noted or found, QE staff apparently notified relevant administrators and managers via an informal process of email or phone calls. EPSSLC operated three groups, the PIC, PET, and PIT. All three are described below. As is evident by these descriptions, EPSSLC senior management should work on making these meetings efficient and should ensure that their contents are tied to the QE department, especially regarding possible intake of data from the PIT, and generation of summary data for the PIC. These types of meetings require a great deal of time of management staff who have many other responsibilities. Efforts should be made to ensure their time is well spent during these meetings. Performance Improvement Council The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Enhancement. According to an EPSSLC	Noncompliance

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		document called, Program Improvement Council Guidelines, the purpose of the PIC is to keep management informed of facility's status in meeting the Settlement Agreement. The document noted that when barriers are identified, a CAP should be developed, that the PIC is an open forum for brainstorming and problem solving, and that it is to be chaired by the Settlement Agreement Coordinator. The monitoring team reviewed minutes from PIC meetings and attended a PIC meeting held during the week of the onsite tour. The group met for an overview initiation meeting in November 2009 and then not again February 2010. The facility director began attending in April 2010. Overall, the minutes indicated some presentation of information regarding the Settlement Agreement, but no problem solving and brainstorming regarding facility operations, generation or review of CAPs, or overall review of the facility's QE program. During the PIC attended by the monitoring team, department heads made brief presentations (similar to their presentations to the monitoring team at the opening meeting of this week's onsite tour), but there was no discussion of issues, problem solving, or review of CAPs. <u>Performance Evaluation Team</u> Performance Evaluation Teams (PET) had been meeting at EPSSLC. There had been three different PETs, one for each set of Settlement Agreement provisions. This had, over the past few months become a single PET. These meetings were also facilitated by the Settlement Agreement Coordinator. A review of minutes from January 2010 through July 2010 indicated inconsistent attendance. <u>Performance Improvement Team</u> EPSSLC operated one PIT. Jeff Moody, Residential Unit Director, chaired and facilitated the PIT. The monitoring team reviewed their meeting minutes from February 2010 (when the PIT began) through May 2010. Attendance appeared to be better than that of the PET meetings and each meeting lasted for about one hour. The minutes indicated that a great deal of data and information were presented, though it was impossible to determine from the minutes if the data and information were presented to the PIT or given as an attachment to the agenda. Either way, almost every department appeared to have submitted data on areas within their disciplines. <u>Corrective Action Plans</u> There was no organized process for developing, implementing, disseminating, monitoring, documenting, or modifying corrective action plans at EPSSLC. No CAPs were submitted to the monitoring team, and although one or two department heads mentioned a CAP when asked by the Settlement Agreement Coordinator during the PIC meeting, there was no indication that they were completed correctly, were	

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		functional, or were useful documents. Further, they were not reviewed at the PIC.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	EPSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
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.	EPSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	EPSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement state policy on Quality Enhancement.

2. Consider whether facility-specific policies in QE might be helpful to the overall operation of the QE program at EPSSLC.

3. Create a facility QE plan that is functional, meaningful, and useful to EPSSLC managers, administrators, and clinicians regarding SA provisions and other areas of service provision (e.g., ICFMR regulations). The plan also needs to include:
    - all requirements of the DADS policy on Quality Enhancement,
    - a narrative,
    - all of the areas listed on page 4 of the policy, and
    - the Health Care Guidelines and Dental Guidelines

4. Provide professional development for QE department staff.

5. Ensure that the QE director's responsibilities for incident management and investigations do not compete with managing the quality enhancement activities of the department and with meeting the requirements of this provision of the Settlement Agreement.

6. Ensure that the work of the Settlement Agreement Coordinator is incorporated, and in sync with, the activities of the QE department.

7. Review whether to continue the use of the QSO.

8. Continue to modify and create quality enhancement tools that are in line with the monitoring team's checklist tools.

9. Ensure all relevant data are submitted to the QE department from all departments at EPSSLC.
10. Ensure validity and reliability of data collected by program auditors.
11. Subject the QE department to quality assurance/enhancement review, feedback, and assessment.
12. Develop a satisfaction measure for individuals, staff, family members and LARs, and affiliated agencies and providers.
13. Develop the recently re-initiated self-advocacy group.
14. Provide program improvement reports as per the policy.
15. Coordinate the responsibilities of the PIC, PET, PIT, and QE department.
16. Implement CAPs when needed, following all requirements of E2, E3, E4, and E5 above.
17. Develop a QE report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Personal Support Teams PDP Process Training Curriculum 9/22/09 o DADS 2009 Your Rights in a State Supported Living Center Booklet o DADS Positive Assessment of Living Skills (PALS) o Training transcripts for seven direct support professionals o Admission Rights Assessment for one individual o Skill Acquisition Plan for one individual o Progress Notes for one individual o Review of the PSPs and addendums for 16 individuals prescribed psychotropic medications (see section J) o Sample of PSPs for: • Individual #13, Individual #73, Individual #57, Individual #12, Individual #55, Individual #23, Individual #2, Individual #110, Individual #31, Individual #36, Individual #90, Individual #92 o Sample of eight PSP addendums • Individual #13- 4/21/01 • Individual #13 - 4/27/10 • Individual #73 - 4/22/10 • Individual #74 - 4/23/10 • Individual #13 - 6/24/10 • Individual #104 - 4/14/10 • Individual #81 - 4/20/10 • Individual #8 - 4/20/10 • Individual #126 – 6/22/10 o Sample of BSPs for • Individual #13 - 4/1/10, • Individual #104 - 7/12/10, • Individual #8 - 12/19/09, • Individual #73 - 6/18/10 • Individual #10 – 3/10/10 • Individual #38 – 3/27/10 o Sample of Safety Plans for • Individuals # 13 5/25/10, • Individual #104 5/19/10 o PSP addendums and assessments used in the development of the PSP for • Individual #12, Individual #25, Individual #44, Individual #96, Individual #124

	Interviews and Meetings Held: o Gloria Loya, QMRP Coordinator o Valerie Grigg, Psychological Services Director o Max Wiant, MD, Medical Director o Facility psychiatrists Observations Conducted: o Observations at residences 506, 507, 508, 509, 510, 511, 512, 513, and Dorms A, B, and C o Observations at the onsite workshop and prevocational program o Observation at the Forever Young program o Human Rights Committee meeting 7/21/10 o Interim PST meetings for Individual #13 and Individual #164 o Health Status Team meeting 7/21/10 o PST meeting for Individual #77
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and, therefore, most of the items required by this provision were either not developed or not yet implemented. As a result, noncompliance was the rating determined for most of the items in this provision. The state policy #004 Protections, Services, Treatments, and Supports dated 2/15/10 was still in draft format. The facility had not yet developed a policy to address this section of the Settlement Agreement. The development of person directed plans was a clear focus of the facility QMRPs, and the QMRP Coordinator was aware of areas that needed to be addressed to improve the person centered planning process. A sample of 17 Personal Support Plans (PSPs) was reviewed and one annual Personal Support Team (PST) meeting and two interim PST meetings were observed during the onsite monitoring visit. The implementation dates on the 17 PSPs reviewed ranged from 7/09 to 6/10. Plans developed in 2010 used the new DADS format dated December 2009. The plans clearly showed an effort to gather information on the individual's needed supports, interests, preferences, and long-term goals. Although much of this information was included in the plan and discussed by the team at PSP meetings, outcomes resulting from planning were often not individualized to reflect the individual's preferences and stated vision, nor did they focus on moving the individual into a less restrictive setting. The cover page of each PSP reviewed using the new format included a list of "what's most important to the person?" and "how

	is this supported?" These lists tended to be individualized and comprehensive. This information would be a great starting point for the development of individualized outcomes, however, it was observed at annual PST meetings and in observation of day programs, that this information was not used to prioritize outcomes for the person. Throughout the monitoring visit, it was noted that there was a very low level of engagement in activities in all programs at all times of the day. Individuals who were engaged in activities were generally involved in meaningless, repetitious task that had little chance of moving them towards more independence and a meaningful day (also see section S of this report). In the PSP meeting observed, a majority of the time was spent reading over assessment information that was written in the draft plan. The individual and most of the meeting participants clearly lost interest in the discussion (also see section T of this report). A way to avoid this and facilitate a more productive meeting would be to send the draft plan out before the meeting and ask team members to review the assessment information prior to the meeting. Then, use meeting time to develop meaningful outcomes and supports. There was no real discussion around what the individual liked to do and how she could be supported to participate in new activities. Outcomes were general and represented no more than a continuation of things she was already doing. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision. The plan should describe who will provide and monitor each support, how the support will be provided, and a schedule of when each support will be needed. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct support professionals responsible for implementing the plan.

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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:	The DADS policy for this section was in draft format at the time of this onsite review. EPSSLC did not have facility policies in place addressing the role of Personal Support Teams (PSTs) or the development of Personal Support Plans (PSPs). QMRPs were scheduled to attend training on developing person centered plans. The facility needs to ensure that the QMRPs have support from all team members and facility administrators to change the current process used to develop PSPs and that all team members understand the underlying philosophy behind the changes. Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan based on the preferences and vision of the individual.	Noncompliance
F1a	Be facilitated by one person from	PST meetings were facilitated by the QMRP whose responsibilities included keeping the	Noncompliance

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	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.	group focused on an agenda and making sure all sections of the PSP were addressed. QMRPs were also responsible for obtaining assessments, coordinating, and monitoring services for the individual. Informal interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to the individuals who they supported. It was not evident that plans were revised when objectives were either completed or when progress was not being made. For example, service plan objective (SPO) progress notes for Individual #124 indicated that he had met criteria for his homemaking skills objective at 100% and had not made progress on his money skills objective; but neither had been revised. The QMRPs were not responsible for developing service objectives which led to implementation of a disjointed plan that provided isolated training opportunities rather than integrating all services and supports throughout the individual's day in a more normal pattern of life. Program Developers were responsible for developing service plan objectives and it appeared that they generally used the same series of objectives for each skill area for most individuals at the facility. Therefore, this provision item was rated as being in noncompliance.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The PST meetings observed during the monitoring visit confirmed that PSTs were comprised of an interdisciplinary team based on the individual's strengths, preferences, and needs. Staff that provided direct support to the individual were present at the meetings and given the opportunity to contribute to discussion. Both the individual and LAR were present at the meeting. Interim PST meetings attended during the monitoring visit also were conducted with an interdisciplinary team in attendance at the meeting. Direct care professionals interviewed confirmed that they attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by ongoing discussion with the QMRP regarding supports and services. All of the direct care professionals interviewed reported that if a service or support was not adequately addressing an individual's need, they could discuss it with the QMRP or other team members and that those team members would address the issue and call the team together if needed. It was evident from a review of PSPs that documentation from a variety of relevant disciplines was reviewed in preparation of the annual PSP meeting. Nevertheless, the PSTs were not comprised of all of the staff who directly provided services and supports to the individuals. For example, there was no integration of psychiatry into the treatment planning process. Per interviews with psychology and	Noncompliance

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		psychiatry staff, psychiatrists were not attending treatment-planning meetings. A review of the PSPs for 16 individuals prescribed psychotropic medication revealed that basic information (e.g., names of medication and dosages) was included. There were, however, no detailed discussion of pharmacological plans or the thought process behind the use of particular medications. For example, in the PSP for Individual # 69, there was a section of the report that stated "discussion of identifying and justification of the need for psychotropic medication" this section was blank. There was, however, information contained in the pharmacy section regarding the need for monitoring due to the prescription of certain medications (see section J13).	
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.	A wide range of assessments were performed prior to PSP development. It was not, however, evident that these assessments were used to address barriers to each person achieving his or her individualized vision and, therefore, this provision item was rated as being in noncompliance. PALS was the functional skills assessment used by the facility and specifically named in the state policy. While this assessment offered a basic checklist of functional skills, it did not include a means of prioritizing skills based on each person's individual preferences. This resulted in generic outcome development rather than individualized outcomes for each person. Additional assessments were completed for each person by specialists and clinicians. Recommendations from these assessments were often vague and were included in isolated plans rather than being integrated into a comprehensive plan for providing support to each person throughout his or her day. For example, Individual #124's OT and SLP assessment indicated that he needed communication and mealtime supports. The communication and meal management section of the PALS assessment were not completed. As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs.	Noncompliance
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As noted in section F1c, it was not evident that assessment results were used to develop, implement or revise PSP supports. The PSP included information from specific disciplines in isolated sections of the PSP, rather than integrating assessment information into one plan that staff could use to support the individual. For this reason as well as those identified in this section F1d, this provision item was rated as being in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Recommendations were not always detailed enough to provide staff with strategies for supporting individuals to achieve ISP outcomes. For example, Individual #124's OT and SLP assessments indicate that he had limited expressive language skills. Other than a vague recommendation in his SLP assessment to utilize a communication book, there were no communication recommendations to support him to achieve his outcomes. His PSP stated that he enjoyed socializing and included an objective to develop social skills. Communication is a primary factor in developing social skills, but there were no strategies related to communication included in the SPO. Use of a communication book was not included in any of his SPOs. According to direct support staff interviewed throughout the monitoring visit, treatment was provided independently, for the most part, by each separate discipline. According to interviews with direct support professionals, therapist, nursing staff, and psychologists did not work with direct support staff to ensure integration of plans into supports provided throughout each person's day. A narrative section in the PSP describing the person, his or her preferences, how he or she spent the day, and what supports were needed throughout the day may help the team see how services should be integrated into a lifestyle rather than looking at supports from each discipline as isolated interventions. Individual #23 had a good description of supports that he needed, his preferences, and activities that he enjoyed in the recreation section of his PSP. This information combined with narrative information from other sections of his PSP would have been a good starting point for developing outcomes and supports. Outcomes in his PSP were limited to the same general outcomes found in most PSPs reviewed. A majority of the PSPs reviewed did not include a summary of services and supports that the individual was receiving. PSPs should clearly address all of the supports that an individual will receive, including a description of the residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided, and what types of supports the individual will need throughout the day. When comprehensive policies are in place to address PSP development, the facility needs to be sure that QMRPs receive updated training on developing plans. QE staff should continue to monitor plan development and provide assistance and training as needed.	

#	Provision	Assessment of Status	Compliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	Community placement was discussed at most PST meetings according to the PSP, though the discussion was limited and little action was taken to move forward with community placement. PSPs indicated that Individuals and their LARs were provided with information regarding community placement. There were some PSPs reviewed that included well developed, fairly comprehensive Living Options Discussions, but it was not evident that this information was included in outcomes and objectives for the individual. For example, Individual #23 had a comprehensive list of preferences and supports that he would need in the community, but outcomes were not developed to move him closer to community placement. There was generally no consideration of community-based day programs or supported employment by the team. Although trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the sheltered workshop on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. The facility had a limited vocational program that offered individuals a chance to work on contract work in a segregated setting. Employment was not discussed in a majority of the PSPs reviewed and the facility did not have a supported employment program. The PSP cover page for Individual #124 noted that "he enjoys working and making money " yet, there was no discussion in his PSP regarding possible supported employment opportunities. Individual #79 had a recommendation in her vocational assessment "To obtain a job in the community in a laundry setting." The team acknowledged that work was important to her and had included an outcome to obtain a job in the community. Her PSP showed that the outcome was on hold "pending doctor's approval." It was not clear why the doctor needed to approve the outcome, but there was no indication that progress had been made on obtaining the doctor's approval. Her OT assessment indicated that she was a "strong candidate for community placement." There were no plans in her PSP to pursue community placement other than visit various community living options as scheduled. Informal interviews with staff in various homes throughout the facility revealed that staff were aware of the rights of individuals whom they supported and there was an understanding that they were responsible for safeguarding each individual's rights. There were clear, easy to understand posters placed in all buildings observed throughout the campus regarding individual's rights.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	This provision will be reviewed in greater detail by the monitoring team following the implementation of newly developed facility policies to address PSP development and 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:		
	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;	PSPs included a table with a list of what was most important to the person. This list was not consistently used to develop outcomes based on the individual's preferences. Teams should use this area of the PSP to list specific things that are important for the individual and then include supports that the person needs to maintain or increase the occurrence of those things in his or her life and address any barriers to occurrence. The PSPs that were reviewed typically had an outcome to participate in some community activity, but plans did not state functional learning that would take place while the individual was in the community. The focus appeared to be on community participation in specific events rather than establishing relationships and membership into the community. Opportunities for community integration at the facility will be reviewed further during future monitoring visits.	Noncompliance
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	As discussed in the summary above, outcomes were not always related to the person's preferences and vision. Most outcomes did not contain enough information to be observable and measurable, and plans were not consistent in addressing supports needed to achieve outcomes. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step. For example, • The PSP for Individual #124 had several action steps that were not clear in stating what level of participation was needed by the individual to complete the outcome and what supports would be needed for successful completion. The following action steps were included in his PSP: a. "Will participate in activities that he is capable of performing." There was no indication as to what type of activities this would include,	Noncompliance

#	Provision	Assessment of Status	Compliance
		furthermore, if he was capable of performing the activity already, what will he be learning? b. "Staff will ensure that he participates in gardening activity before and after meals on a daily basis." The plan did not indicate what level of participation was needed to successfully complete this outcome. • Individual #66 had the objective "to ensure that he participates in listening to music activity." His level of participation for successful completion of this outcome was not defined. It is not clear what learning may be achieved through this activity.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The facility needs to put into place specific procedures for developing PSPs that integrate all protections, services, and supports that the individual needs. PSPs were developed with an apparent goal to capture each individual's needs, goals, preferences, and abilities in one document as described by each treating discipline, but there was little evidence of true integration of all services into one comprehensive plan. Plans need to include not only a list of services and supports that the person is receiving, but also a description of how and when those supports will be implemented and monitored. For example, communication strategies were not integrated into SPOs and Activity Plans written by other team members. A description of communication abilities was not individual-centered in the PSP. It only directly quoted the Communication Skills assessment by the SLP. It was more of a discipline-specific approach than a more holistic approach that described the person as a person.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Plans designated staff responsible for implementation of the objectives by discipline, but lacked specific methods for implementing outcomes as discussed in F2a2 above. Although target dates for completing objectives were included in most cases, target dates for completion of outcomes were generally one year from the implementation date rather than being based the individual's rate of learning.	Noncompliance
	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	Outcomes did not include specific interventions, strategies, and supports individuals might have needed to achieve outcomes (see comments throughout this report). Outcomes were not always functional either at the facility or in the community. For example: • Individual #124 had a money management outcome to "identify a quarter from a group of items." A more functional application of this outcome would be to identify coins needed to purchase an item from a vending machine on campus or a store in the community. It is not clear what the other items might be or how the outcome would lead to independence in managing his money.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #66 had completed the outcome to "identify a coin from a group of items" and progressed to the outcome "i.d. a quarter from a group of basic coins." The overall objective was that he would be able to purchase his soda. Again, a more functional application would be to have him choose the correct coin and place it in the vending machine to enable him to make the skill more functional. Individual #66 also had a community awareness objective to "identify a firefighter" from flashcards. The outcome had a projected completion date of 5/31/11. Spending a year identifying a picture of a firefighter is not a meaningful way to prepare an individual for community placement. • Individual #96 had an outcome to "fill in the top section of a mock employment application." Data indicated that she had successfully completed this outcome. There was no indication that the team had considered progressing forward to filling out a "real" job application, though her vocational assessment recommended pursuing community employment. There were functional objectives found in some of the PSPs reviewed. Individual #44 had a money skills objective to "hand the cashier money to purchase an item of his choice with hand over hand assistance." The objective was to be implemented while out in the community.	
	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.	Most SPO activity plans included a statement regarding frequency of implementation and data collection and stated that Program Developers would collect data and write progress notes. QMRPs were assigned monitoring of training. Data collection generally consisted of a check mark to indicate session criteria was met or not met. It did not indicate what level of participation was involved and any barriers that may have contributed to lack of progress. Data collection should indicate the individual's level of participation, supports needed, and response to the activity. Without this information, it is difficult to implement the plan consistently and modify supports to ensure a greater level of success.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The facility did not have a process to ensure coordination of all components of the PSP. See comments throughout this report regarding the lack of integration of services for individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The PSPs did not provide clear information that would guide direct care staff in providing necessary supports. See specific details and examples in F2a above.	Noncompliance
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.	The facility will need to develop a policy that requires monitoring of PSP implementation and criteria for reviewing data and modifying plans as needed. Efficacy of all support plans should be evaluated by team members with a system that includes input from direct care professionals responsible for implementation, oversight, and monitoring by plan developers.	Noncompliance
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	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. There was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual plans initially or when they were updated or modified. This provision of the Settlement Agreement will continue to be reviewed in upcoming monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
	least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.		
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.	A sample of new admissions was not reviewed during this monitoring visit. All PSPs in the sample reviewed had been developed within the past 365 days. As noted in F2a, plans were not revised when objectives were met or no progress was being made. There was evidence that PSTs met when significant events occurred throughout the year, but PSP addendums reviewed were generally a discussion of events rather than a revision to the plan. For example, the team met for Individual #126 to discuss recent displays of aggression. Although strategies in her PBSP were no longer effective, it was not revised.	Noncompliance
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.	As noted above, quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E of this report). The QMRP Coordinator was responsible for reviewing plans, but was waiting on upcoming training to begin monitoring plans in line with this provision. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	Noncompliance

Recommendations:

1. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.
2. Ensure that QMRPs have support from administrative staff and team members to implement changes to the current person centered planning process.

3. Continue team building efforts at the facility to foster an attitude that encourages and supports integrated services

4. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

5. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, and therapy services, along with a schedule of when these services will be provided, where they will be provided and what types of supports the individual will need throughout the day to support participation.

6. Integrate psychiatry into the treatment planning process

7. Include information regarding the individual's psychotropic medication regimen in the PSP.

8. All action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual is needed to successfully complete each step.

9. Implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o EPSSLC policy and procedure manual o EPSSLC Organizational charts for facility and departments o QMRP caseloads o Printout of slides from opening meeting presentation by facility department heads regarding the facility's progress o DCP staffing report from Jeff Moody o Job specific on the job training form from Julie Norman o Sample of daily listing of sick calls and appointments, 7/22/10 o EPSSLC Plan of Improvement, 6/10/10 o EPSSLC Plan of Improvement Supplement, 6/10/10 Interviews and Meetings Held: o Tony Ochoa, Facility Director o Dr. Ken Wiant, M.D., medical director, Dr. Sal Molina, incoming medical director, and Dr. Julie Moy, DADS medical director o Sandy DeLong, Chief Nurse Executive o Jeff Moody, unit director o Julie Norman, director of competency training and development o Facility psychiatrists o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite tour. Observations Conducted: o Presentation made to monitoring team by senior staff at EPSSLC at opening meeting of onsite monitoring tour o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Conduct of psychiatry clinics
	Facility Self-Assessment: Please see the Executive Summary section of this report.

	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement. The facility had not identified a lead manager for this provision of the Settlement Agreement. Clinicians across the facility were not familiar with this provision. Moreover, a lack of integration of clinical services was evident at EPSSLC and this provision was found to be in noncompliance. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	A plan was not in place to address this item, policies and procedures did not exist, and the absence of integrated services was evident. Consequently, this provision item is rated as noncompliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. A number of discussions with the facility director, medical directors, chief nurse executive, lead psychologist, unit director, admissions and placement coordinator, and quality enhancement director, as well as with staff at various levels of management, within clinical services, and at the direct care level indicated that meaningful integration of clinical services was not evident throughout the facility. Surprisingly, clinical staff at EPSSLC were not aware of the components of this provision of the Settlement Agreement and no one was assigned lead responsibility for this provision. Presentation books shown to the monitoring team were absent of any meaningful information. It appeared that the facility was awaiting direction from the state office regarding this provision. Even so, there was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. The monitoring team was aware that the medical department was in the process of transitioning to a new medical director with the upcoming retirement of the current long-term medical director. The monitoring team was pleased to see that a new medical director had been identified and that he had been hired early to provide a number of months of overlap with the outgoing medical director. The monitoring team looks	Noncompliance

#	Provision	Assessment of Status	Compliance
		forward to working with the new medical director towards the meeting of this, and other relevant, provisions of the Settlement Agreement. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. The facility director had worked most of his career in many different positions at EPSSLC. He was intimately familiar with facility operations and will need to play a key role in the meeting of this provision of the Settlement Agreement. Some examples of the absence of collaborative integrated clinical work are below. • In psychiatry clinic the psychiatrist and psychologists attempted to work together to decrease individuals' undesired behaviors, but their impact on clinical outcomes was severely limited by the insensitive data system used by the psychology department (see K4), and the overall absence of data-based decision making. In one clinic encounter observed during the tour, the psychiatrist added medication based on a verbal report, with no data to validate the accuracy of the statement (see J10). • The lack of meaningful integration of clinical services was evident in the absence of skill acquisition plans targeting individuals communication needs (see S1), and the absence of training and feedback of DCPs as to how to best engage individuals by the active treatment department (see S1). • Although the PNMP Committee included Nurse Case Managers, QMRPs, dietitians, and Habilitation Therapies Services, the meetings were a rote exercise during which information about the individual was stated, but there was limited evidence that there is true collaboration in the process of assessment, observation, data collection and analysis, and monitoring (see sections O and P in this report). • As discussed below in section J of this report, there was little to no integration of psychiatry with the other medical specialties. The psychiatrists had little communication with the medical director, and communicate with the neurologist through written physicians orders with instructions for the medical director to impart specific information to the neurologist. • The death review for Individual #22 took more than six months to complete. • Many clinical staff were not familiar with the details of the Settlement Agreement (though they were familiar with their own POI). Even though work will be needed, EPSSLC was not without collaborative work. Some examples are presented below. • Psychology was helping the QMRP and program development departments with the development of desensitization programming.	

#	Provision	Assessment of Status	Compliance
		• The medical director described many examples of communication across DCPs in residential, day, and vocational services and examples of their providing useful information to medical staff. • Sick call occurs daily in each home at approximately 7 a.m., providing a good opportunity to communication. • The medical director was available and on call every day. Many clinicians at the facility described the medical director as being readily available to them. • According to the Chief Nurse Executive, recent changes included the recruitment of clinical professionals who were committed to the team approach and were willing to "do it together" in order to ensure that individuals received the care and treatment that they needed • The Health Status Team (HST) met regularly. The HST was comprised of physicians, nurses, therapists, dieticians, psychologists, and other clinical professionals who were responsible for the regular review and assessment of individuals' level of risk across areas of need. (Note, however, that elsewhere in this report, the HST and the facility's approach to assessing and managing risk are noted to be fraught with problems.) In addition to the need for explicit activities to occur to move EPSSLC towards the integration of clinical services, other activities will help support meeting the requirements of this provision item. First, an advanced practice registered nurse was recently added to the medical department and her position may set the occasion for additional collaborative and integrated service provision. Second, although not a requirement of the Settlement Agreement, the monitoring team suggests that the facility director spend time in the facility's program and clinical areas at various times during the week to directly observe staff and individuals. This can contribute to administration's knowledge and support for the ongoing improvement in integration of clinical services.	
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	A plan was not in place to address this item, however, the medical department reported that non-facility clinician recommendations were considered and reviewed. The monitoring team will need to see documentation of its occurrence in order for this provision item to be considered to be in substantial compliance. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. The monitoring team will review documentation at the next onsite visit to establish whether there is adequate documentation regarding disposition of the recommendations of non-facility clinician	Noncompliance

#	Provision	Assessment of Status	Compliance
	supports and services.		

Recommendations:

1. Develop and implement policy.
2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.
3. Adopt a health risk screening tool and assessment process that includes the review and analysis of specific, objective, measurable data to codify/measure health risk.

<table>
<tr><th>SECTION H: Minimum Common Elements of Clinical Care</th><th></th></tr>
<tr><td rowspan="2">Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o EPSSLC policy and procedure manual
o EPSSLC Organizational charts for facility and departments
o QMRP caseloads
o Printout of slides from opening meeting presentation by facility department heads regarding the facility's progress
o DCP staffing report from Jeff Moody
o Job specific on the job training form from Julie Norman
o Sample of daily listing of sick calls and appointments, 7/22/10
o EPSSLC Plan of Improvement, 6/10/10
o EPSSLC Plan of Improvement Supplement, 6/10/10
o Review of records of 16 individuals prescribed psychotropic medication, see section J

<u>Interviews and Meetings Held</u>:
o Tony Ochoa, Facility Director
o Dr. Ken Wiant, M.D., medical director, Dr. Sal Molina, incoming medical director, and Dr. Julie Moy, DADS medical director
o Sandy DeLong, Chief Nurse Executive
o Jeff Moody, unit director
o Julie Norman, director of competency training and development
o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite tour.
o Discussions with medical, pharmacy, nursing, and dental staff.

<u>Observations Conducted</u>:
o Presentation made to monitoring team by senior staff at EPSSLC at opening meeting of onsite monitoring tour
o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report</td></tr>
<tr><td>Facility Self-Assessment:

Please see the Executive Summary section of this report.</td></tr>
</table>

	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite tour to address this provision of the Settlement Agreement and as a result activities were not occurring at EPSSLC to meet this provision of the Settlement Agreement. Therefore, this provision is found to be in noncompliance. Similar to section G described above, medical and clinical staff were not aware of the details or contents of this provision and little had been done to address the items in this provision. The presentation book did not have any meaningful information in it. Nevertheless, across the facility, there was great desire for coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. The facility, however, lacked direction in how to obtain this outcome. This was due in part to (a) the recency of attention to this provision, (b) great confusion as to who was responsible for each component and the monitoring of each component of this provision, and (c) a plan of improvement that did not provide guidance or direction regarding specific actions to be taken.

#	Provision	Assessment of Status	Compliance
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.	A plan was not in place to address this provision item and the facility did not have any procedures in place to ensure assessments and evaluations were completed on a regular basis and in response to developments or changes in an individual's status. This was also acknowledged in the facility's POI. There was no formal plan in place to address this. The medical staff performed evaluations on sick call based on acute medical problems and the need for follow-up. There was no requirement for an interval evaluation such as a quarterly assessment. For all 20 individuals reviewed by the monitoring team listed in section M of this report, all 20 had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner, however, problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Further, comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. In 17 of the 20 records reviewed, nursing assessments failed to provide a complete, comprehensive review of each individual's past and present health status and needs. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individual's clinical problems, needs,	Noncompliance

#	Provision	Assessment of Status	Compliance
		and actual and potential health risks. OTs, PTs, SLPs all conducted annual assessments for all individuals regardless of risk level. There were interim assessments completed for specific problems identified, generally referral-based. The response time appeared to be appropriate though doctor's orders were not reviewed to validate in that regard. It was noted, however, that for discharge from the hospital, individuals were usually assessed within 24 to 48 hours. There were several examples of clinical practices at the facility that were not consistent with generally accepted professional standards of care in psychology. These included: • the absence of timely and complete psychological evaluations (see section K6), • incomplete functional assessments (see section K5), • PBSPs that were not consistent with current ABA standards (see K9) • Absence of necessary behavioral systems (see K3, K4, and K10), and • Incomplete skill acquisition plans (see S1) As discussed in the psychiatry section of this report (J), the facility was delinquent with regard to completion of annual psychiatric evaluations. Per a review of the records of 16 individuals prescribed psychotropic medications, no updated annual evaluations were located. The most recent evaluations were dated in 2009. Facility staff were well aware of this delinquency, and retained the services of a locum tenens psychiatrist, who, was assigned only annual evaluations.	
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.	There was no policy in place to require or guide the activities required to meet this provision item. For example, this was difficult to determine, as per a review of psychiatric evaluations (albeit older ones), monthly medication reviews, and quarterly medication reviews, there were no diagnostic formulations outlining the specific symptoms that individuals were experiencing, such that met the criteria for a specific diagnosis. For additional information regarding this issue, please refer to the discussion of provision J8. Medical diagnoses, however, appeared to be consistent with the International Statistical Classification of Diseases and Related Health Problems.	Noncompliance
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	EPSSLC did not have a plan or procedure in place to ensure that treatments and interventions were implemented timely and were clinically appropriate. The facility's POI, and discussions with the facility medical directors, indicated that they were not yet assessing whether this provision item was being met.	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate based upon assessments and diagnoses.	Examples of treatments not implemented timely or not based upon appropriate assessments or diagnoses are described in this report, including regarding changes in psychiatry treatment (Section J), updates and modifications to PBSPs based upon the functional assessment and/or a lack of progress (Section K), and changes in risk status based upon occurrences of medical-related events (Sections I, M, and O).	
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.	Neither a plan nor activities were in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used across all disciplines. Consequently, this provision item was rated as being in noncompliance. This was further supported by the information in the facility's POI and in the monitoring team's discussions with the facility's medical directors. There were, generally, no measurable goals established for interventions provided. Documentation was more anecdotal in nature, making it difficult to track progress and compare data to determine progress over time. The medical directors were aware of nationally known clinical practice guidelines and engaged with the monitoring team in discussions about how these might be utilized at the facility and perhaps across the state. The facility and state should be sure to address clinical indicators for all areas of clinical practice, not only in medical care and nursing services.	Noncompliance
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.	A plan was not in place to address this item and, therefore, this item is rated as being in noncompliance. The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report (sections I, M, and O), the HST did not look at all aspects of health (it looked primarily at risk) and had numerous problems as indicated in these other sections of this report. In addition, some monitoring of side effects of psychotropic medications was occurring at the facility (see section J of this report).	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two	Neither a plan nor activities were in place to address this item and without clinical indicators identified (see H4 above), treatments and interventions cannot be modified in response to clinical indicators.	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, treatments and interventions shall be modified in response to clinical indicators.		
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.	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance. Facility management also acknowledged that this provision item was not yet being addressed.	Noncompliance

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.

3. Consider an electronic medical record; this may be an effective way to implement clinical indicators and provide for accurate tracking.

4. Ensure that there is adequate medical staffing to allow for the provision of quality services.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006: At Risk Individuals o EPSSLC Policy: Level of Supervision, Revised 7/28/09 o DADS Risk Assessment Tools, dated 8/31/09 o Sample of PSP Addendums addressing risk levels: • Individual #29 6/22/10 • Individual #97 6/22/10 o Sample of PSP Addendums addressing restraints: • Individual #13- 4/21/01 • Individual #13 - 4/27/10 • Individual #73 - 4/22/10 • Individual #74 - 4/23/10 • Individual #13 - 6/24/10 • Individual #104 - 4/14/10 • Individual #81 - 4/20/10 • Individual #8 - 4/20/10 o EPSSLC List of Individuals with Dysphagia as of 6/25/10 o Health Status Team Meeting minutes since 3/1/10 o List of individuals with medical diagnosis of Pica o List of individuals that required mealtime assistance o List of individuals with poor oral hygiene o Log of ER visits since 1/10 o Log of Hospitalizations since 1/10 o List of 10 individuals with the most injuries 3/1/10 - 5/331/10 o List of 10 individuals causing the most injuries to peers 3/1/09 – 5/31/10 o List of individuals and their risk level in the following areas: • Seizures • Challenging Behaviors • Dehydration • Osteopenia/Osteoporosis • Skin Integrity • Weight • Respiratory • Constipation • Injury • Aspiration o PSP and Health Risk Assessment for Individual #175

- PSP and Health Risk Assessment for Individual #12
- PSP and SLP evaluation for Individual #183
- BSP for Individual #104
- PSP for Individual #96

Interviews and Meetings Held:

- Max Wiant, MD, Medical Director
- Molina Salvador, MD Physician
- Valerie Grigg, Psychological Services Coordinator
- Gloria Loya, QMRP Coordinator
- Mike Reed, Lead Investigator
- Two Direct Support Professionals
- Informal interviews with various direct care professionals, QMRPS, nursing staff, and psychology support staff in homes and day programs throughout campus

Observations Conducted:

- Observations at residences 506, 507, 508. 509, 510, 511, 512, 513, and Dorms A, B, and C
- Observations at the onsite workshop and prevocational program
- Incident Management Meeting 7/20/10 and 7/23/10
- Human Rights Committee meeting 7/21/10
- Mini PST meeting for Individual #13
- Health Status Team meeting 7/21/10
- Death Summary Review meeting 7/22/10

Facility Self-Assessment:

Please see the Executive Summary section of this report.

Summary of Monitor's Assessment:

The items in this provision were rated as being in noncompliance.

State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The rating forms allowed individuals that were at risk to be rated low if plans were in place to address specific risk. This practice continued to be a concern of the monitoring team because it did not alert staff that individuals at risk needed to be monitored more frequently for signs and symptoms of risk. The other overwhelming concern of the monitoring team regarding risk ratings was that plans addressing risk were often not sufficient or were not monitored adequately placing the individual at risk even with a plan in place.

Risk levels often conflicted with information included in the PSP by specific disciplines. Comprehensive

	risk reviews that consider and address factors that contribute to each risk area need to be completed and all staff need to be aware and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. The monitoring team recommends that the facility clarify the purpose of the identification of at-risk individuals. A Health Status Team (HST) was in place that met monthly. The team was chaired by the facility Medical Director. Observation of a HST meeting revealed that it was an interdisciplinary review of risk factors. The team's efficacy was inhibited by current state policies for assigning risk levels. There was consensus among staff at the facility that contributing factors to challenging behaviors at the facility were lack of effective behavioral support interventions, overcrowded homes, and grouping of individuals with challenging behaviors. The facility did not have a plan in place to address any of these factors. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy mandated a risk review at least every six months for each individual by a Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. Determining risk levels was done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. The risk system used within the HST and the PNM committee were not integrated. For example, as described in more detail below in section I2 and in section O of this report, an individual was identified at high risk for aspiration, yet she was listed as being at low risk by the HST. There were a number of examples of inconsistencies between these two groups. There was a prevailing philosophy to reduce the risk level if there was an intervention in place. The monitoring team attended the Health Status Team Meeting (HST) held during the week of the onsite tour. The meeting was well attended, coordinated, and ran efficiently. The HST reviewed risk factors for each individual on the agenda and discussed recommendations. As noted above, resulting risk level assignments were not adequate for assuring protection and monitoring of the individual.	Noncompliance
I2	Commencing within six months of	The policy stated that the Health Status Team (HST), chaired by the Primary Care	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Provider, would ensure a preventative approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high risk condition was identified, the PST would meet within five working days to formulate a plan. The plan had to be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was stabilized and the risk level was reduced. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels are assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. Some examples of inconsistencies in risk scores and actual risk factors for individuals are provided below. • Individual #13 had a risk level of 2 indicating medium risk for challenging behaviors. During the week of the onsite tour, the monitoring team observed four restraint incidents for aggression involving this individual. This would indicate that he was at high risk for challenging behaviors. He did have a behavior support plan in place, but staff indicated that the strategies were not effective. • According to the PSP for Individual #175, she was diagnosed with GERD and osteopenia. Her risk levels were rated as low in both of these categories by the HST. Her PSP did not indicate a risk level for either diagnosis. • The PSP and facility list of individuals at risk for falls indicated that Individual #96 was at low risk for falls. She utilized a rollator walker with gait belt and a shower chair, indicating that she was at risk for falls. She was rated a medium risk for osteopenia/osteoporosis even though she had a PNM plan in place to reduce the risk of fractures through careful handling and positioning due to	

#	Provision	Assessment of Status	Compliance
		brittle bones. • Individual #12's PSP stated that she required a motion sensor when she was in bed, a wheelchair, shower bench, kick boxing helmet with face guard, gait belt, knee pads, and chair with padded armrest due to the high risk of falls from uncontrolled seizures. The list provided to the monitoring team indicated that she was at low risk (level 3) for seizures and falls. • The PSP for Individual #25 indicated that she was at low risk for aspiration and choking, though she had a PBSP in place addressing placing non-edible toxic or dangerous materials in her mouth. In June 2009, gauze was found in her stool. She was also on a pureed diet due to the risk of aspiration and choking. • Individual #104 was assigned a medium risk level for challenging behaviors, though his BSP indicated that he had been restrained 14 times in the last six months for behavioral intervention and data in the BSP indicated a total of 80 incidents of aggression. • Individual #183 was not on the list of individuals at risk for aspiration or choking, though her SLP assessment indicated that she was at low risk provided there was compliance with ordered diet textures and swallow safety guidelines in her PNMP. It further noted that if she were provided regular foods, these would pose a choking risk.	
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.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. The PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Direct care professionals reported that they were notified of changes in plans by therapist or their supervisor and implementation of changes began immediately. Throughout the monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were generally able to accurately identify risks or identify supports needed to monitor those risks. As noted throughout this report, plans were often not carried out as written, therefore, individuals remained at risk. For example, Individual #100 had a plan in place for the use of a VNS for seizure activity. The magnet to be used with his VNS was kept in a zippered pouch in a binder with the plan. It was noted during the first observation at his home that the magnet was missing from the pouch. During a second visit, the magnet was in the zippered pouch, but staff were not able to locate the book for several minutes. Staff were required to document that they had the book with them at all times. Documentation for two shifts on 7/21/10 and two shifts on 7/22/10 was blank.	Noncompliance

Recommendations:

1. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

2. All staff should receive individual specific training on each safety and health care risk identified for the individuals they are assigned to support.

3. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support.

4. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction.

<table>
<tr><th>SECTION J: Psychiatric Care and Services</th><th></th></tr>
<tr><td>Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:<ul style="list-style-type:circle">
EPSSLC organizational chart
A list of individuals admitted within the last six months
For psychiatry:
The number of budgeted positions;
The number of staff;
The number of contractors;
The number of unfilled positions, including the number of unfilled positions for which contractors currently provide services;
The current FTE; and
The actual staff-to-individual ratio for each position, including staff and contractors.
A list of daily, weekly, monthly, quarterly meetings that typically occur at the facility
A table of contents of the individuals' records
Any policies, procedures and/or other documents addressing the use of pre-treatment sedation medication
For the past six months, a list of individuals who received pre-treatment sedation medication for medical or dental procedures that included date the pre-sedation was administered, and the name dosage, and route of the medication, and an indication of whether a plan was in place to minimize the need for the use of pre-treatment sedation medication
Any auditing monitoring data and/or reports addressing the use of pre-treatment sedation medication
A description of any current process by which individuals receiving pre-treatment sedation were evaluated for any needed mental health services beyond sensitization protocols.
A spreadsheet of individuals prescribed psychotropic/psychiatric medication, and for each:
Diagnoses; and
Medication regimen (including psychotropics, non-psychotropics, and PRNs, including dosage of each medication and times of administration)
A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use
A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use
A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date
Facility-wide data regarding polypharmacy, including intra-class polypharmacy
A list of individuals being monitored for tardive dyskinesia
List of new admissions since 1/1/10, and whether a Reiss scale was used</td></tr>
</table>

	o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend. o A list and copy of all forms used by the psychiatrists. o Examples of forms used to document side effects, e.g., AIMS, MOSES, DISCUS o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists. Job description of psychiatrists. o A list of all psychiatrists, including board status, if employee or contracted, and number of hours working per week o CVs of all psychiatrists o For the past six months, minutes from the committee that addresses polypharmacy. o For the last 10 newly prescribed psychotropic medications: • Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication • signed consent form • PBSP • HRC documentation o Since 1/1/10, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). o Last 10 post sedation nursing evaluations o At risk policy o Restraint policy o All policies related to informed consent o Lab matrix regarding psychotropic medications o Individuals assigned to each psychiatrist o These documents: • psychological update • most recent history and physical • psychiatric annual evaluation • psychiatric progress notes from January 2010 to present • MOSES and DISCUS from January 2010 to present • health care plan for 2010 • quarterly drug reviews for 2010 • medical consultations for 2010 • integrated progress notes for 2010 • physicians orders for 2010 • laboratory examinations for 2010 • imaging studies for 2010 • EKG for 2010 • most recent Personal Support Plan and all addendums • most recent Behavioral Support Plan

	- Restraint Checklists for 2010 - Consents for 2010 o For the following individuals: - Individual #69, Individual #83, Individual #104, Individual #108, Individual #14, Individual #31, Individual #13, Individual #109, Individual #47, Individual #26, Individual #26, Individual #30, Individual #78, Individual #8, Individual #89, Individual #66. o The most recent history and physical examination, laboratory examination results for 2010, psychiatric progress notes for 2010, and consents for 2010 for the following individuals: - Individual #74, Individual #155, and Individual #37. Interviews and Meetings Held: o Richard M. Orr, M.D. facility psychiatrist o Sandy Delong, R.N., Director of Nursing o Mary Ann Clark, R.N., Nursing Operations Officer o Valerie Kipfer, Nursing Director, DADS o Max Wiant, M.D., facility Medical Director o Bernardo Aleksander, M.D., facility psychiatrist (via telephone) o Amista Salcido, Pharm.D., Pharmacy Director o Julie Moy, M.D., DADS Medical Director o Angel Rodriguez-Chevres, M.D., facility psychiatrist o Valerie Griggs, M.A., BCBA Observations Conducted: o Observation of psychiatry clinic with all three facility physicians for these individuals: - Individual #82, Individual #53, Individual #31, Individual #8, Individual #75, Individual #100, Individual #172 o Observation of individuals in the home environment: - Individual #66, Individual #13, Individual #104, Individual #31, Individual #14, Individual #53, Individual #69 o Observation of PSP meeting o Critical Incident Debriefing o PST Emergency staffing for Individual #13
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Although psychiatry consultations were occurring, EPSSLC was found to be in noncompliance with all of the items in this provision of the Settlement Agreement.

	The psychiatry department at the EPSSLC was in need of a strong leader. The clinic was not organized, nor were the physicians integrated into the overall treatment program at the facility. The physicians were not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, frequently made medication additions or adjustments in absence of data regarding specific target symptoms. Additionally, while staff from nursing and psychology attended psychiatry clinic, these clinic encounters were rapid and, per observation during this onsite monitoring tour, were not thorough with respect to a review of available records or interaction with the individual. Interviews with staff revealed that in most cases, the staff members were aware of the challenges and need for increased structure and integration with respect to psychiatry. Unfortunately, the facility was not able to retain sufficient psychiatric clinical consultation time due to a reported lack of providers available in the area.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The facility did not have a lead psychiatrist, or a permanent full time psychiatric physician onsite. There were two part time consulting psychiatrists, Drs. Aleksander and Rodriguez-Chevres, who both reported extensive experience in the treatment of individuals with developmental disabilities. Both were board certified by the American Board of Psychiatry and Neurology. Dr. Rodriguez-Chevres was also certified by the American Board of Forensic Medicine. Richard Orr, M.D., the locum tenens psychiatrist retained by the facility two weeks prior to the initiation of this monitoring tour, reported a history of work experience in the field of developmental disabilities. He was employed at the San Angelo facility in April 2008. Per a review of Dr. Orr's curriculum vitae, he was certified by the American Society of Addiction Medicine. There was no documentation of board certification by the American Board of Psychiatry and Neurology. Although the psychiatrists practicing at the facility were board certified, the report that follows below will indicate several areas of concern with regard to their practice at the facility. While it was recognized that many of the challenges could be due to the lack of consultation time available, the lack of appropriate data they were provided, and the lack of their integration into the overall facility treatment program, improvements in the quality of services provided will be reviewed over the course of the monitoring period. Given the difficulties noted in the discussion sections of the provisions addressed below, it was impossible to assign a rating of compliance in this area.	Noncompliance
J2	Commencing within six months of the Effective Date hereof and with	Per interviews with the two psychiatrists contracted to provide services at the facility, individuals were seen in clinic a minimum of once per quarter for their quarterly	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	medication review. The psychiatrists also performed monthly medication reviews, that, per their report and observed during the monitoring tour, were based on verbal report of staff members present in the psychiatry clinic (e.g., the nurse case manager, psychologist, QMRP, direct care staff) and some record review. The psychiatrists admitted that, due to time constraints, they were behind in the completion of annual evaluations. Accordingly, no annual psychiatric evaluations were located for the year 2010. With the retention of a locum tenens psychiatrist one week prior to the initiation of this monitoring tour, the psychiatrists were hopeful that this deficiency could be corrected. Concerns regarding the adequacy of psychiatric clinical availability remained, even with the recruitment of the new full time locum tenens physician. For further discussion regarding this, please see section J5 below. A review of 16 records revealed varying quality of the documentation in the monthly and quarterly medication reviews. There were no diagnostic formulations noted, nor were detailed descriptions of the justification for the use of specific psychopharmacological agents located. Given these deficits, it was difficult to determine the adequacy of the diagnosis and treatment for the individuals and, therefore, this provision item was found to be in noncompliance. It is hoped that increased clinical consultation time will allow for improvements in overall quality of the clinical interaction and documentation thereof. The facility could consider quality assurance monitoring or the implementation of a peer review process. For further discussion regarding diagnostic practices see the discussion below in sections J6 and J10.	
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.	Per this provision, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). When comparing the list of individuals prescribed psychotropic medications against the list of individuals with PBSPs, four individuals (Individual #94, Individual #62, Individual #42, and Individual #120) did not have documentation of a PBSP. The quality and utility of the PBSPs is the subject of provisions relating to psychological services, discussed in section K of this report. During the monitoring tour and per the record review performed following, it was apparent that individuals were receiving frequent emergency psychotropic medications during periods of agitation. During the onsite tour, this practice was observed on two occasions. On one occasion, Individual #13 was in a physical restraint at the time the monitoring team arrived in the home. The individual was initially crying loudly and then after a time, stopped. The individual was quiet for approximately 45 seconds, then stated "okay…okay…," however, when staff did not release the individual from the hold, he resumed crying and struggling against the hold. The individual eventually quieted and was released after what was described by psychology staff to be a specific predetermined time period that the physical hold would last. This individual was placed in a physical	Noncompliance

#	Provision	Assessment of Status	Compliance
		hold on two more occasions that afternoon. Ultimately, the medical director ordered an IM injection of benzodiazepines. The injection was ordered without a clinical contact between the physician and the individual, and without the input of psychiatry. A review of the physician's orders for this individual revealed five documented injections of IM medication since 3/17/10. The physician's orders also revealed that this individual was placed in "horizontal restraint" on 25 occasions per the order of the medical director. Again, the psychiatrist was not involved in these events. A review of this individual's psychiatric progress notes for the same period of time revealed scant documentation that the treating psychiatrist was aware of the restraint episode or the administration of additional medication. Per the monthly medication review performed 6/23/10, the psychiatrist noted that there were five incidents of restraints in April 2010. The psychiatrist noted knowledge of one episode of restraints in a review 6/2/10, one episode in a review 4/8/10, and five episodes in a review 3/24/10. As such, the psychiatrist documented knowledge of 48% of the individual's restraint episodes. There was no documentation noted of the knowledge of the administration of emergency psychotropic medication by the facility medical director. A review of the record of Individual #104, chosen at random from the records available for off site review, revealed that on 10 occasions between 3/2/10 and 7/11/10, intramuscular benzodiazepines were administered per the order of the facility medical director. A review of the psychiatric progress notes dated 5/25/10, 6/3/10, and 7/1/10 did not reveal documentation of the psychiatrist's knowledge that additional emergency medication had been administered The above case illustrations were typical of the lack of collaboration, or documentation of collaboration, in the records of individuals at the facility. It was also illustrative of the facility practice of utilizing IM medications in response to behavioral challenges without the input or knowledge of psychiatry. This is indicative of the need for integration of psychiatry into the treatment program at the facility. While all individuals prescribed medication had diagnoses noted in the record, there were concerns regarding the justification and case formulation for specific diagnoses as well as the indications for psychotropic medications prescribed to address the diagnoses in the record. For further discussion regarding this issue, please see the discussion below in sections J8 and J13.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is	Per interviews with psychology staff, desensitization plans were in place for individuals who were being seen in dental and medical clinic, and these plans were being authored by program development staff. Psychology staff indicated that they had not been involved in the development of these programs and were not aware of the contents of	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	them. During this tour, members of program development were not interviewed. This will be addressed during the next monitoring tour. In order to determine compliance with this provision, the personal support plans (PSP) for four individuals, noted per the document request as having required pretreatment sedation for medical or dental clinic, were reviewed. In all four cases, there was an entry in the PSP regarding desensitization. In three cases, the desensitization plan was similar, specifically, in the plan documented for Individual #108; the plan read "…staff to massage the gums/teeth/tongue with a toothette in order to increase…cooperation with dental visits." The plans for Individual #47 and Individual #30 were nearly identical. Individual #104's plan stated, "…will visit the dental hygienist office twice a week and will be able to enter the room upon gestured prompts." Other than these brief references to the dental desensitization plans, no other information was located in the records reviewed. During future tours, the records will be reviewed to determine the presence of additional information and/or more detailed desensitization plans for individual's requiring pretreatment sedation for dental or medical appointments. Regardless, the above plans were inadequate. Strategies should be individualized and offer a stepwise method to acquaint the individuals with the clinic rather than providing one intervention in order to address the individuals challenges pertaining to participation in dental and medical examinations. From a review of the PSP in the above noted records, it was difficult to determine the progress that the individual was making. There were tracking percentages, indicating that individuals had allowed the specific intervention (in most cases, the percentages were 100), however, there was no information as to whether this had been effective in decreasing the need for pretreatment sedation. In fact, the above noted individuals continued to require pretreatment sedation. As such, the plans should have been modified. It was noted in all records above that when individuals required pretreatment sedation, nursing staff closely monitored them. Integrated progress notes revealed documentation of the post sedation monitoring via progress notes and documentation of the actual administration of the medication and the individual's vital signs and mental status via the completion of the restraint checklist. Documentation of the coordination of the pretreatment sedation process with psychiatry was not located in the records. A review of the psychiatric progress notes for the individuals noted above did not reveal documentation that the physicians were aware that the individual received additional medication for sedation, or that they were aware of the effects of same.	

#	Provision	Assessment of Status	Compliance
		This was concerning given the potential for interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. Additionally, medications utilized for pretreatment sedation could result in unwanted challenging behaviors or sedation that could be mistaken by psychiatrists as symptoms of exacerbations of mental illness or as side effects from the regular medication regimen.	
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.	There were two part time contract psychiatrists providing services at the facility. One physician was onsite at the facility five hours per week. He had a caseload of 49 individuals. This equated to 49 medication reviews monthly and approximately 16 quarterly medication reviews monthly. This physician had a total of 21 clinical hours available per month (allowing for 4.2 weeks per month). Therefore, the physician had a total of 21 hours to perform 65 different clinical contacts. This equated to more than three clinical contacts per hour. This did not include participation in any meetings, collaboration or treatment planning. The second contract psychiatrist was onsite three hours per week. This physician had a caseload of 40 individuals. As such, he had even less time available per clinical encounter. The week prior to the monitoring tour, the facility contracted with a locum tenens company to obtain a psychiatrist forty hours per week. Per interviews with the physicians and psychology staff, there were no plans to change the individual's assigned psychiatrist. The immediate goal for psychiatry was to update the annual psychiatric evaluation utilizing the new locum tenens psychiatrist. Once that task was complete, there was a plan to split caseloads appropriately. At the time of the tour, there were 1.2 FTE of psychiatric clinical contact hours at the facility (48 hours per week or 201 per month using 4.2 weeks per month). With a current total caseload of 86 individuals, this related to a total of 114.6 clinical contacts per month (86 monthly reviews and an average of 28.6 quarterly reviews per month). This equated to 1.75 hours per clinical contact. This did not include annual evaluations, participation in meetings or treatment planning. As such, the current level of psychiatric clinical contact time was inadequate. Additionally, the facility was in need of a lead psychiatrist who could spearhead the collaborative efforts with psychology and integrate the psychiatry clinic into the facility.	Noncompliance
J6	Commencing within six months of the Effective Date hereof and with	The facility did not have policy and procedure outlining the process for psychiatric clinic. The facility utilized the psychiatric evaluation and psychology accepted the diagnostic	Noncompliance

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	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.	impressions from the psychiatric evaluation. A review of the records of the 16 individuals prescribed psychotropic medication revealed no up-to-date psychiatric evaluations. Per an interview with both the psychiatrist and the director of psychology, the psychiatrists were behind with respect to annual psychiatric evaluations. The recent recruitment of a locum tenens psychiatrist allowed psychology staff, who were reportedly responsible for scheduling the individual's clinic appointments, to schedule annual psychiatric evaluations for numerous individuals. A review of the new psychiatrist's schedule revealed that he was slotted to perform annual evaluations for the majority of the day. A cursory evaluation of some older annual evaluations was performed (these were dated in the summer of 2009). These evaluations did not comport to the requirements of Appendix B of the Settlement Agreement. As the facility was in the process of updating the individual's annual psychiatric assessments, a more robust review of these documents will be conducted during the next monitoring tour. There were other issues regarding psychiatric clinic that merited discussion. Three psychiatric clinic encounters were observed during the tour. During all three, members of the individual's treatment team, specifically, the psychiatrist, the nurse case manager, the psychologist, and the QMRP were in attendance. Per staff interviews, these staff generally attended clinic. Despite their attendance, the interactions between the staff members were brief and cursory. All three clinic locations were hot, crowded, and did not lend themselves to performance of a full clinical review. For example, in two clinic locations, all staff members with the exception of the psychiatrist were required to stand for the entire clinic. This did not encourage the full review of the individual's case information. It was noted that in one clinic, the physician did not review the individual's record, but rather received an oral report from the nurse case manager, taking notes as the case manager gave a brief oral presentation (from memory). In addition, informal commentary from staff revealed their frustration if the physician did not complete the consultation quickly enough, ostensibly due to their physical discomfort. In one clinic encounter, the physician was able to complete a quarterly medication consultation (including review of the documents, and observation of the individual) in seven minutes, excluding dictation. A second individual was seen in 10 minutes and a third individual in 12 minutes. This rapidity did not allow for a comprehensive review of documents, discussion with the other attendees or for any meaningful interaction with the individual and represented a serious departure from generally accepted professional standards of care in psychiatry.	
J7	Commencing within six months of	The Reiss Screen is an instrument that was developed to identify individuals who may	Noncompliance

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	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.	need a psychiatric evaluation. Per an interview with the Director of Psychology, the facility had performed one Reiss Screen; this was done 6/25/10 for an individual who was recently admitted to the facility. This individual was reportedly the only admission to the facility in the past six months. The Director responded positively to queries regarding the utility of the instrument, and indicated that it was her goal to screen all individuals at the facility who were currently treated with psychotropic medications. This would not be an appropriate use of the instrument because the screen was not needed for individuals who had a current psychiatric assessment. There were, however, 51 individuals residing at the facility who were not enrolled in psychiatric clinic and would be appropriate for Reiss Screening.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinic, the amount of collaboration between the disciplines was limited to the psychology staff providing the number of target behaviors that occurred in the intervening period to the psychiatrist during clinic. Therefore, this provision item was rated as being in noncompliance. While some of the data were documented in the record as the impetus for medication adjustments, both psychiatry and psychology staff voiced concern regarding the accuracy of data collection, and the accuracy of the individual target behaviors. It was also notable that there were no graphs of data presented to the physician, and as such, medication decisions made during the three clinic observations performed during this monitoring period were based on the information provided at the time of the clinic. The decisions were not based on a long range view of the individual's behavior/symptoms presentation. A review of the psychological and psychiatric documentation for 16 individual records did not reveal case formulations that tied the information regarding a particular individual's case together.	Noncompliance

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		Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no documentation located of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions.	
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.	Per interviews of both psychiatrists and psychology staff, the psychiatrists did not attend meetings regarding behavioral support planning, and they were not involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance. Psychiatrists verbalized a willingness to become more involved, but indicated that a lack of clinical contact time had made this impossible. Psychiatrists were aware that in many cases, the behavioral interventions, behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports were not coordinated with the psychiatric diagnosis or psychotropic medications. Further complicating this picture, was the fact that while the psychiatrists documented an indication for the medication, they did not regularly document the target symptoms for a particular medication. The list of individuals prescribed psychotropic medication at the facility was compared to the list of individuals at the facility who had a positive behavioral support plan (PBSP). Of the 86 individuals prescribed psychotropic medication, four did not have documentation of a positive behavioral support plans (Individual #120, Individual #42, Individual #62, and Individual #94). The positive behavior support plans and psychiatric documentation of 16 individuals prescribed psychotropic medication were reviewed. It was difficult to determine collaboration between the disciplines via a review of the record. In a randomly chosen example from the 16 records reviewed, Individual #108 had a positive behavioral support plan that documented target behaviors including aggression, self-injurious behavior, and uncooperative behavior. The target behaviors were defined, but did not corroborate with the psychiatric diagnosis in the record. The PBSP noted that the functions of the aberrant behaviors were "escape/avoidance…the result of boredom…homesick and cries…becomes uncooperative." Although there was a documented diagnosis of a mood disorder and anxiety disorder, there were no documented concerns regarding these symptoms influencing the individual's behavior. The psychiatrist had intermittently documented concern regarding depression, however, this was not reflected in the PBSP. Also, the individual was prescribed a long acting	Noncompliance

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		antipsychotic medication, and akathesia was not considered as an etiology for the difficulties by either psychology or psychiatry. The above case example was illustrative of the lack of coordination between the disciplines and how this can have a negative effect on the treatment of the individuals. In this case, the individual has had dosages of the decanoate antipsychotic increased and as a result experienced drooling, requiring additional medication.	
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.	A review of the records of 16 individuals at the facility who were prescribed various psychotropic medications did not reveal documentation of an individualized specific risk/benefit analysis with regard to treatment with medication. There were general comments included in the positive behavioral support plans and in the Human Rights Committee (HRC) review of the positive behavior support plans, however, these were not individualized and did not include input from the psychiatrist or primary care physician. The HRC meeting review document was signed by the nursing case manager. During the tour, both the facility psychiatrists and psychology staff reported that the psychiatrists were not involved in the PST process. The psychiatrists also indicated that they rarely had interactions with the individual's primary care physician. The lack of a collaborative thoughtful approach to the prescription of psychotropic medication was observed during the monitoring tour. During psychiatry clinic, staff indicated that an individual had not been sleeping. They did not state how long this had been occurring, what the antecedent to this behavior could have been, and they did not present any sleep data or any other objective information. The psychiatrist did not request any additional data, and prescribed a sleep agent during the seven-minute clinical encounter. This case illustrated the need for overall improvement in the quality of data provided to the physician, the increased analysis of this data by the physician and the need for improvement in the risk/benefit analysis. The input of the psychiatrist, primary care physician and nurse must be documented in order for the facility to meet the requirements of this provision.	Noncompliance
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 facility had in place a review system for polypharmacy that was centered in the pharmacy department. EPSSLC had recently recruited a new pharmacy director who was ambitious and energetic. A review of the quarterly drug regimen documents located in 16 individual health care records revealed that the reviews were comprehensive and offered appropriate guidance	Noncompliance

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	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.	and recommendations to the physicians. In all cases, the treating psychiatrist signed the reviews. While this was good, this provision item required this review to be performed monthly, and as such, the frequency of this monitoring will need to be adjusted. The facility was in the process of developing a committee to address polypharmacy. Per a review of the document request for minutes from this meeting, the committee was in the process of development with plans to implement the meetings in September 2010. Per a review of the active psychoactive medication list by drug class provided by the facility pharmacy, there were a total of 61 individuals prescribed antipsychotic medications at the facility. Of these, 10 individuals were prescribed two antipsychotics and two were prescribed three antipsychotics. The records of the two individuals prescribed three antipsychotics were reviewed. In both cases, there was a good quarterly drug regimen review performed by the pharmacy. In both cases, the pharmacy recommended that the psychiatrist document the justification for the utilization of three atypical antipsychotic medications in the clinic note. Review of the psychiatrist's quarterly medication review documentation for both of these individuals showed, in one case, a cursory explanation of the reason for polypharmacy. In the case of Individual #83, the physician documented that the three medications were being utilized to address "unremitting, severe mania" and that the medications had been prescribed, "over a period of time…added one after the other." Interestingly, one of the three atypical antipsychotic medications prescribed in this case have clinical indications for the treatment of bipolar depression, and may have actually exacerbated the individual's difficulty. This, however, was not noted in the physician's documentation. In the case of Individual #104, the psychiatrist did not note the rationale for the prescription of three atypical antipsychotic medications. Furthermore, the psychiatrist noted at one visit, that a specific medication would be reduced, and in the next visit, the psychiatrist increased the dosage. There were a total of 45 individuals prescribed antidepressant medications. Of these, two were prescribed two antidepressant medications. There were 40 individuals prescribed anxiolytic medications. Of these, five were prescribed two anxiolytic medications. Six individuals were prescribed stimulant medication and there was no polypharmacy noted in this class. Twenty-one individuals were prescribed sedative medication and there were two individuals prescribed two sedative medications. Of the total of 86 individuals prescribed psychotropic medication from any class, 19 were prescribed one medication, 19 were prescribed two medications, 20 were prescribed three medications, 14 were prescribed four medications, 10 were prescribed five medications and four were prescribed six medications.	

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		Review of the records of the four individuals prescribed six psychotropic medications did not reveal adequate justification for this level of polypharmacy in any of the records. In all four cases, there were quarterly pharmacy drug regimen reviews located. None of the records reviewed revealed a detailed description of the potential interactions or problems inherent in the prescription of multiple psychotropic medications.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The review of a sample of 16 records revealed documentation that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) was being performed by the Nurse Case Manager, however, data gleaned from the MOSES and DISCUS exams were not consistently utilized in the quarterly medication reviews done by psychiatry. There was some variability in the frequency of monitoring. For example, in the case of Individual #8, the most recent DISCUS was 2/23/10. In the most recent quarterly medication review performed for this individual on 5/18/10, the psychiatrist did not note the absence of the monitoring documents. Per a review of the records of 16 individuals prescribed antipsychotic medication, completed DISCUS and MOSES evaluations were located in the records. Other than the one outlier noted above, all were within the required time limit at the time of the most recent quarterly review. A review of the quarterly medication review documents for these 16 individuals revealed that in 31% of the cases, there was no notation of the DISCUS or MOSES results, and no documentation of the presence or absence of abnormal movements. In an effort to address this issue, the facility could consider physician education regarding documentation requirements or quality assurance monitoring with ongoing corrective action.	Noncompliance
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	At the time of the onsite monitoring tour, the facility psychiatrists were not participating in the PSP process. Their contact with the PST members occurred during psychiatric clinic. As stated above, this contact was brief and, per observation of three clinic dates, unsatisfactory. There was no separate treatment-planning document regarding psychotropic medications and, per interviews, this was accomplished via the monthly and quarterly medication reviews. There were brief references to psychotropic medications in some of the PSP documents reviewed. In review of the psychiatric documentation from the records of 16 individuals, it was difficult to determine the validity of the psychiatric diagnoses that were in the record. There were no annual psychiatric evaluations located for 2010, and, per the interviews	Noncompliance

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	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.	with the physicians and psychology staff, these had not been performed. A review of available documentation in the form of monthly and quarterly medication reviews revealed diagnoses, however, there was no documentation of the specific symptoms the individuals were experiencing, or diagnostic formulation included. As such, it was impossible to determine if the individual met criteria for a specific diagnosis per the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or per the Diagnostic Manual-Intellectual Disability (DM-ID). Further review of the psychiatric documentation revealed that in approximately 50% of the 16 cases reviewed, there was some connection between the behavioral target symptoms being monitored and the diagnosis in the record. On the other hand, there were several cases of individuals diagnosed with thought disorders (i.e. psychotic disorders), but there was no documentation that psychosis was being monitored. Additionally, there were several cases of individuals diagnosed with mood disorders, however, there was no documentation that mood was being monitored. There were also three individuals, in the cases reviewed, prescribed more than one medication for an indication of "sleep," however, sleep data were not included in the target behaviors. Interviews with both psychology staff and the psychiatric physicians revealed that they were aware of the need to revise the target symptoms and behavioral data being collected. Physicians also indicated that it would be helpful if behavioral targets were defined (e.g., aggression as evidenced by…). In review of psychotropic medications prescribed in the 16 cases reviewed, the documentation of a specific indication for medication without a corresponding diagnosis was evident 33% of the time. In another 25% of the cases, the indications could be loosely attributed to the diagnoses in the record (e.g., a prescription for a benzodiazepine for a target symptom of anxiety in an individual with a diagnosis of Major Depressive Disorder). Unfortunately, the lack of a thoughtful planned approach to psychopharmacological interventions was blatantly obvious in the case of Individual #13. This individual reportedly had increased agitation and aggression, requiring multiple episodes of restraint in recent weeks, however, until the monitoring team suggested it, the behavioral data for the individual had not been graphed against medication changes. In review of the graph created during the tour, it became evident that this individual had medication changes on seven dates since May 2010. On one of those dates, the dosages of three separate psychotropic medications were adjusted (either titrated upward or downward) and the dosage times of a fourth medication were altered.	

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		The above approach makes it impossible to determine the effect of medication alterations. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment) the physician can determine the benefit or lack thereof of a medication adjustment.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The facility policy and procedures regarding "Rights and Restrictive Practices" effective date 7/11/02 with a review date of 2/10/03, and "Prescribing of Psychoactive Medication Clinical Monitoring of Psychoactive Medication" effective date 5/23/07 were provided in response to a request for policy and procedure regarding informed consent. The policy and procedures were not inclusive of forms, although forms regarding informed consent were located in the individual's medical records. Review of the informed consent documents in the medical record revealed that these forms were essentially checklists to ensure that specific information was addressed via the informed consent process. The form stated that "a description of any side effects or risks reasonably to be expected" was attached to the form, however, despite a review of 16 medical records, no attachment was located. Per an interview with the facility Pharmacy Director, medication information sheets were printed out via the pharmacy and provided to the individual or his or her legally authorized representative (LAR) during the informed consent process. Another issue was that the consent forms often contained signatures for authorization of treatment that were illegible, and the typed signature of the physician or designee giving explanation was frequently documented on a different date than that of the signed authorizing party. Additionally, the documents located in the records reviewed were generic, and did not include the indications for a particular medication nor the target symptoms. Given the importance of informed consent, the development of an individual policy and procedure regarding this topic could be considered. Additionally, review of the medical records revealed information regarding the individual and their guardianship status however, this information was not included in the psychiatric annual evaluations or progress notes. Easy identification of an individual's guardianship status for the purposes of consent is necessary. Inclusion of this information in the demographic data located in the beginning of the psychiatric evaluations/progress notes may assist in this regard.	Noncompliance
J15	Commencing within six months of the Effective Date hereof and with	Per interviews with all three facility psychiatric physicians as well as the facility medical director, there was no coordination of treatment efforts occurring between psychiatrists	Noncompliance

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	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.	and the neurologist. During one of the three psychiatric clinics observed as part of this monitoring tour, one practitioner wrote an order providing information to the facility medical director including a request for the medical director to communicate information included in the order to the neurologist. Both the psychiatric physicians and the facility medical director admitted the need for collaboration. This was evident as there are 46 individuals at the facility (39% of all individuals prescribed medication per the list provided by the facility) prescribed antiepileptic medication indicated for seizure activity with additional medications prescribed for various and sundry psychiatric indications. Unfortunately, psychiatric physicians were not integrated into the PSP process at the facility. Per interviews, this was previously due to the limited number of available contract hours. Now that the facility retained a full time psychiatrist via locum tenens, staff verbalized plans to have the psychiatrist participate in the PSP process. This will not be an easy task with regard to the neurologist. Per the interview with the medical director, the facility had limited neurology contracted consultation hours (a total of three hours per month), which did not allow for participation in the PSP process. Interviews revealed that medical staff were not hopeful regarding obtaining increased neurology consultation hours. This was due to a reported lack of practitioners in the community. The facility may want to consider alternate methods of obtaining neurology consultation (e.g., telemedicine, contracting with local medical schools and/or residency training programs, a neurology floater position serving more than one DADS facility).	

Recommendations:

1. Integrate psychiatry into the overall treatment program at the facility. This would include involving the psychiatrists in decisions to utilize emergency psychotropic medications and, more importantly, in discussions regarding treatment planning and behavioral support planning to reduce the need for restraint, either chemical or physical.

2. Individualize the desensitization plans for dental and medical clinic. Ensure that psychiatry is aware of when an individual requires pretreatment sedation and documents this knowledge in his or her progress notes.

3. Consider the recruitment of a lead facility psychiatrist.

4. Monitor psychiatrist's workload in order to objectively determine the need for additional clinical contact hours. This can better be performed once a baseline is established for meetings/clinical coordination with other disciplines.

5. Ensure that the target behaviors/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate.

6. Consider the utilization of scales and screeners normed for this population in an effort to obtain objective data regarding symptoms as well as to monitor symptom response to targeted interventions.

7. Draft and implement policy and procedure governing psychiatric clinic at the facility.

8. Complete overdue annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B.

9. Examine the physical location and process of psychiatric clinic at the facility. Changes in the milieu of the clinic may be beneficial in that staff (including psychiatry) will be comfortable and more amenable to a richer clinic experience.

10. Implement the Reiss screen for new admissions as well as those individuals who do not have a current psychiatric evaluation.

11. Formalization of the PSP process to review risk/benefit ratios for the prescription of psychotropic medications.

12. Implement the plans for the committee to review polypharmacy.

13. Increase the frequency of the pharmacy quarterly drug regimen reviews to monthly in order to meet the requirements of the settlement agreement.

14. Improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented.

15. Improve documentation of psychiatric review, and clinical correlation of DISCUS and MOSES examination results.

16. Improve psychiatric documentation to include a diagnostic formulation and justification for a specific diagnosis.

17. Review the target behavioral data for each individual to determine if appropriate data points are being collected. In order for the data to be usable, it should be graphed with medication information (i.e., start dates of medication, stop dates of medication, and dosage adjustments) included.

18. Ensure that the indications for specific medications correspond to the diagnosis, and that appropriate defined behavioral data points are being monitored.

19. Individualize the process for Informed Consent.

20. Consider a detailed Informed Consent Policy and Procedure.

21. Integrate psychiatry into the PSP process.

22. Explore options to increase the availability of neurology consultation.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #79, Individual #81, Individual #68, Individual #69, Individual #164, Individual #108, Individual #132, Individual #12, Individual #85 o Positive Behavior Support Plans (PBSPs) for: • Individual #37, Individual #73, Individual #78, Individual #69, Individual #13, Individual #27, Individual #79, Individual #81, Individual #68, Individual #80, Individual #116, Individual #70, Individual #108, Individual #82, Individual #164, Individual #132, Individual #12, Individual #104, Individual #126, Individual #51, Individual #99, Individual #23, Individual #50, Individual #31, Individual #36, Individual #10, Individual #90, Individual #109, Individual #14, Individual #9, Individual #85, Individual #61, Individual #172 o Behavior Support Plan (BSP) Addendums for: • Individual #69, Individual #37, Individual #109, Individual #13, Individual #14, Individual #56, Individual #104, Individual #108 o Six months of PBSP Reviews for: • Individual #116, Individual #80, Individual #37, Individual #70, Individual #126, Individual #73, Individual #9, Individual #109, Individual #90, Individual #10, Individual #50, Individual #23, Individual #51, Individual #99, Individual #13, Individual #27, Individual #61 o Psychological Evaluation Updates for: • Individual #80, Individual #116, Individual #37, Individual #70, Individual #161, Individual #9, Individual #73, Individual #126, Individual #69, Individual #109, Individual #104, Individual #14, Individual #10, Individual #90, Individual #13, Individual #27, Individual #35, Individual #50, Individual #23, Individual #99, Individual #172 o Spreadsheet of psychological evaluations for each individual at EPSSLC (not dated) o Spreadsheet of PBSPs and review dates for each individual at EPSSLC (not dated) o Competency Check for Behavior Support Plan (not dated) o List of Psychologists employed at EPSSLC, dated 6/28/10 o Handwritten graph of number of restraints for Individual #13 <u>Interviews and Meetings Held</u>: o Valerie Grigg, MA, Psychology Department Director o Marisela Franco, MA, Associate Psychologist o Veronica Avita, Assistant Director of Programs

	<u>Observations Conducted</u>: o Personal Support Team meeting: • Staff attending: Alex Euzarrago (QMRP), Susan Abbott (Program Developer), Valerie Grigg (Director of Psychology), Julian Ponce (Direct Care Professional) • Individual Discussed: Individual #13 o Psychiatry Clinic Rounds: • Staff attending: Dr Rodriguez, Psychiatrist; Dr. Orr, Psychiatrist • Individual Presented: Individual #8 o Human Rights/Behavior Treatment Committee meeting: • Staff attending: Helen Alvarez (Assistant Ombudsman), Aurora Ramos (Direct Care Professional), Ramona Gutierrez (QMRP), Debra Woodruff (Program Compliance Coordinator), Melinda Blystone (RN Case Manager), Claudia Padilla (Associate Psychologist), Valerie Grigg (Director of Psychology) • Individuals Presented: Individual #84, Individual #157, Individual #99, Individual #116, Individual #57, Individual #106, Individual #14, Individual #78, Individual #13, Individual #3, Individual #27, Individual #9 o Observations occurred in every day program and residence at EPSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: None of the items in this provision were found to be in substantial compliance with the Settlement Agreement. It is important to note, however, that there was progress toward compliance in several provision items. The most obvious need at EPSSLC relative to this provision is to ensure that the psychologists are competent in applied behavior analysis (ABA). Psychologists with training and experience in ABA are an essential component to achieving improvements in data collection and analysis (K4), behavioral assessment (K5), the quality and effectiveness of Positive Behavior Support Plans (K9), and the establishment and management of essential behavioral systems (K3,K4, K10, K11, and K12). Finally the facility needs to ensure that psychological assessments are current and complete (K5, K6, and K7). EPSSLC

	has taken important steps toward improving the psychologists' competence in ABA by hiring a director with ABA training (K2), and enrolling all the psychologists in programs to enhance their behavioral skills (K1). EPSSLC's Plan of Improvement (POI) established long-term goals for compliance with this provision. Because many of the items of this provision require considerable change to occur in the way psychology services are provided, and because it will take some time for EPSSLC to make these changes, it may be useful for EPSSLC to also establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by this provision item and as evidenced by the absence of professional certification and by the quality of the programming observed at the facility. At the time of the onsite monitoring tour, one of the facility's six psychology department staff (the director) was a Board Certified Behavior Analysis (BCBA). Therefore, the majority of Positive Behavior Support Plans at EPSSLC were not developed by a BCBA. The facility did, however, have a clear plan for increasing the number of psychologists who possessed a BCBA. Three of the remaining five psychologists were enrolled in a BCBA program at the time of the onsite tour. Additionally, the remaining two psychologists were scheduled to begin BCBA class work in August of 2010. The monitoring team wishes to acknowledge the efforts taken by the psychology staff and the facility regarding the obtaining of BCBA certification. Further, the monitoring team wishes to acknowledge the actions of the DADS central office to support the psychologists in their professional development by making classes accessible and by arranging for appropriate supervised experience. It was clear that the facility was working very hard to develop Positive Behavior Support Plans (PBSPs) that promoted growth, development, and independence while ensuring the safety, security and freedom from undue restraints of the individuals they served. Nevertheless, the monitoring team believed that, in general, the PBSPs were not as effective as necessary to adequately address the behavioral needs of many of the individuals residing at EPSSLC (see K9 below for a more detailed review of PBSPs).	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year,	EPSSLC employed a Director of Psychology who possessed an advanced degree (Masters Degree) and certification as a BCBA. She did not, however, possess at least five years experience working with individuals with intellectual or developmental disabilities. The	Noncompliance

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	each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	Director of Psychology had been working with this population since 2007. Psychology staff reported positive interactions and professional support from the Director of Psychology. Additionally, the director had promoted several procedures implemented to promote improved clinical outcomes. These include ensuring that all psychologists received training in ABA (see K1), improvements in data collection (see K4), use of a methodology for assessing integrity of PBSP implementation (see K11), and enhancement of psychological services other than PBSPs (see K8).	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	One of the primary purposes of peer review, as specified in this provision item, is to ensure the quality of PBSPs by providing an educational opportunity for psychologists to enhance their skills of assessment and treatment of challenging behaviors. Peer reviews accomplish this by providing the opportunity to present cases and comment on the quality of other psychologist's case conceptions. Additionally, peer review provides an opportunity for supervisors to teach important aspects of ABA. Therefore, peer review members should consist of, at minimum, PBSP authors and those who supervise the implementation of plans. Additionally, peer review should be structured so that PSBP authors and supervisors can present cases whenever they have concerns, ideas, are not achieving progress, and so forth. At the time of the onsite review, the facility held weekly Human Rights Committee (HRC) and Behavior Therapy Committee (BTC) meetings. Staff interviews, observation of these meetings, and review of minutes, indicated that the purpose and content of these meetings did not constitute peer review meetings as described above. The purpose of these meetings was primarily administrative (e.g., to assure that the individual's behavior warranted a PBSP, the plan was not unnecessarily restrictive), rather than to assess or improve the quality or effectiveness of the PBSPs. Finally, review of minutes indicated that typically only one or two psychologists attended these meetings, making true peer review unlikely to have occurred. In order to achieve substantial compliance with this provision, EPSSLC needs to either restructure the BTC committee so that it includes the majority of psychologists, and so that all participants understand that one of the purposes of the meeting is educational. Alternatively, the facility could establish a separate peer review meeting that consists of PBSP authors and their supervisors. Additionally, at the time of the onsite review, there was no evidence that the facility was conducting external peer review. The monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of, at minimum, other Texas DADS BCBAs and supervisors (perhaps by teleconference).	Noncompliance

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		The monitoring team engaged in numerous discussions regarding peer review with the psychology staff during the onsite review and was appreciative of their positive response. The monitoring team looks forward to the facility's development of both types of peer review. Operating procedures for both internal and external peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	At the time of the onsite review, the data collection methodology used at EPSSLC did not conform to ABA generally accepted professional standards and, therefore, this provision item has been rated as being in noncompliance. In the majority of cottages, direct care professional (DCP) staff recorded target behaviors at the end of the day, rather than when they occurred throughout the day. This type of data collection did not readily lend itself to reliable data collection. Since the baseline monitoring review, however, the facility began to improve this aspect of data collection by introducing hourly data collection for approximately 20% of the individuals with PBSPs. EPSSLC's POI indicated that hourly data collection would be completed for all PBSP data by the end of the year. Another weakness of the data system at EPSSLC was its insensitivity to behavior change. Although target and replacement behaviors were measured, during the onsite tour, only frequency data were collected. An adequate data system should be sensitive to each individual's needs. That is, the data system needs to be able to accurately assess both behaviors that occur at low rates, as well as behaviors that occur at very high rates (e.g., stereotypies, undesirable verbal behavior). Often very high frequency data require the use of a different system of data collection, such as a time sampling or duration measure. It is recommended that the facility expand its data collection system to allow it to accurately assess the occurrence of all target and replacement behaviors. Direct Care Professionals interviewed all indicated that they did have input in the establishment of data collection systems. No one, however, could show the monitoring team documentation of DCP involvement in the data system. It is recommended that DCP input in data system development be documented by DCP presence at meetings, or summarized in psychologists' training notes (see K11). The most direct method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex for some DCPs to collect reliably (e.g., ABC systems that require the collection of multiple antecedents and consequences for each target behavior). Under those conditions, the data system may need to be modified (e.g., use of fewer target behaviors, move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the onsite tour of EPSSLC, data reliability	Noncompliance

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		(i.e., IOA) was not collected. It is recommended that the facility consistently collect IOA for all target and replacement behaviors in each residential and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained, or data systems modified, if scores fall below those goals. On a positive note, targeted behaviors were consistently assessed and analyzed individually, and PBSP targeted and replacement behaviors were graphed and regularly reviewed by a psychologist. All target and replacement behaviors reviewed were graphed monthly. That is, each datum point represented one month of data. Some behaviors, however, need to be graphed more frequently to ensure that sufficient data-based decision making can occur. Monthly data points, for example, would not allow one to identify the effects of a new medication or change in the PBSP for several months. A more sensitive data system (i.e., each datum point representing weekly data or even daily data) that identifies behavioral trends quickly could assist the psychiatrist or psychologist in the most effective use of a medication or treatment intervention. It is recommended that EPSSLC graph targeted and replacement behaviors at a frequency necessary to make data-based treatment decisions. The following example illustrates the importance of reliable data, sensitive to individual needs, and graphed at a frequency necessary to make effective assessment and treatment decisions: • During the onsite review, Individual #13 was engaging in severe physical aggression and dangerous behaviors throughout the day. His behavior was resulting in multiple physical restraints per day. The monitoring team attended a Personal Support Team (PST) meeting to address Individual #13's precipitous increase in dangerous behavior. Attempts to understand the reason for his change in behavior did not result any definitive hypothesis or specific plan to decrease his dangerous behavior. One explanation for the absence of a data-based treatment plan following the meeting was that the data on target behaviors were thought to be unreliable. Subsequent review by the monitoring team of Individual #13's data in his cottage revealed that approximately 25% of the hourly boxes for target and replacement behaviors were left blank, confirming that these data were likely unreliable and would not be useful for making data-based decisions. Additionally, available data were graphed by the month, making it difficult, if not impossible, to identify if any environmental events proposed as possible factors contributing to his increase in dangerous behavior(e.g., changes in PBSP, change in residential setting, medication), were related to his behavior change. The next day the Director of Psychology re-graphed Individual #13's restraint data (thought to be more reliable than other target behaviors because of the	

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		mandated paperwork associated with restraints) by week (rather than by month), and highlighted the occurrence of the environmental factors discussed in the PST meeting. The resulting graph clearly revealed that multiple medication changes were associated with Individual #13's dramatic increase in dangerous behavior and subsequent restraints. After reviewing those data, the team made the data-based decision to systematically investigate his medications. Monthly notes documenting the progress of target and replacement behaviors were completed for each individual with a PBSP. Review of at least six months of progress was completed for 17 individuals. Thirteen individual's PBSP data indicated no change, or an increase, in target behaviors over the six month review period. Despite this apparent lack of progress for the majority of PBSPs, the monitoring team could find evidence of PBSP modification, retraining of staff, change in an antecedent procedure, and/or additional data collection, in only three of these plans. It is important, when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, and changes to the PBSP, or attempts to collect additional information (i.e., modification to the functional assessment), retrain staff, etc., occur immediately and are documented in the progress notes. Progress toward this recommendation were reflected in the following individual's progress notes: • Individual #10 and Individual #90's progress notes indicated an absence of progress, and their progress notes stated that staff would be retrained in specific aspects of their plan. • Individual # 51's progress note indicated that a new baseline would be implemented to better understand one of her target behaviors (see K5 for two additional examples of data-based program modifications). The PBSPs stated that plans would be modified if the individual's PST indicated that there was no progress. The criterion for determining no progress and modification should be more specific than "if there was no progress" and, instead, be stated in a more objective, and individualized manner, such as, "If aggression is not decreased to X per week for two consecutive weeks by X date, the plan will be reviewed by the psychologist, QMRP, and home manager and appropriate modifications will be made." In other words, the criterion to assess progress needs to be individualized, based upon data, and indicate what actions are to occur (i.e., team review). The specific treatment changes and modifications, of course, cannot be pre-determined.	
K5	Commencing within six months of	This provision item was rated as noncompliance due to the absence of psychological and	Noncompliance

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	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.	functional assessments, and due to the need for the content of both assessments to be more comprehensive and complete. <u>Psychological Assessments</u> Fifty percent of the individuals at EPSSLC did not have a psychological assessment. A spreadsheet documenting the dates of psychological assessments at the facility indicated that 68 individuals did not have psychological assessments. The 69 individuals with psychological assessments had annual psychological updates which contained a review of the individual's intellectual ability, an assessment of adaptive ability, and a review of personal history. There was no screening for psychopathology or assessment or review of biological, physical, and medical status. Additionally the intellectual and adaptive scores reported did not include the test used to determine the assessment score, and the date of the assessment was not included. Each individual's record should contain a psychological assessment that consists of an assessment of intellectual ability, adaptive ability, and biological (or physical) status. Additionally the assessment should include a personal history as well as a screening for psychopathology and behavioral issues. Finally the assessment should identify the name of the test or measure used to make the assessment, and the date the assessment was administered. <u>Functional Assessments</u> A spreadsheet containing individuals with a PBSP and its review date, indicated that 95 individuals at EPSSLC had PBSPs at the time of the onsite review. Only nine of these individuals, however, had functional assessments. All individuals with a record or assessment reflecting a behavioral disturbance should have a functional assessment completed. The nine functional assessments reviewed utilized three different formats. It is recommended that all functional assessments at the facility use the same format. An effective functional assessment should contain at least the following elements: • Direct and indirect measures of targeted behaviors reflecting a process or instrument widely accepted by the field of applied behavior analysis • Differentiation between learned and biologically based behaviors • Identification of setting events and motivating operations relevant to the undesired behavior • Identification of antecedents relevant to the undesired behavior • Identification of consequences relevant to the undesired behavior • Identification of functions relevant to the undesired behavior • Identification of functionally equivalent replacement behaviors relevant to the	

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		undesired behavior • Summary statements identifying the variable or variables maintaining the target behavior • Identification of preference and reinforcers All of the functional assessments reviewed identified antecedents and consequences hypothesized to be relevant to the undesired behavior. Two functional assessments (Individual # 132 and Individual # 79) attempted to differentiate between learned and biologically based behaviors. All of the functional assessments identified hypothesized reinforcers or functions of undesired behavior, but two functional assessments (Individual #164 and Individual #108) did not include the individual's most potent reinforcers or replacement behaviors (although replacement behaviors were identified in their PBSPs). All nine functional assessments attempted to identify setting and motivating events. Six of the assessments were mislabeled as a functional analysis. It is recommended that the facility choose one functional assessment format that includes all of the above components. Since the functional assessments and the PBSPs were generally presented together, the above components could be included in either the functional assessment or PBSP. Two of the functional assessments reviewed (Individual #132 and Individual #79) differentiated between direct and indirect measures. The indirect tools used included the Functional Analysis Screening Tool (FAST), and the Motivation Assessment Scale (MAS). These two functional assessments also reported using direct observation as a method for identifying the function of undesired behaviors. Their direct observations, however, focused on general observation of an individual, rather than on the measurement and analysis of specific target behaviors (e.g. ABC data). As discussed in the baseline monitoring report, ideally, the indirect component of a functional assessment would reveal some common themes that then can lead to working hypotheses concerning the variable or variables potentially affecting an individual's target behaviors. These hypotheses could then be further refined (or abandoned) based on the results of direct components of the functional assessment (i.e., direct data collection). If the behavior analyst is confident that indirect and direct measures have suggested clear sources of control of the targeted behavior, then the functional assessment is complete, and the results of the assessment can be used to develop the PBSP. If the results of the functional assessment remain unclear, or if the PBSP is not producing the desired results, the behavior analyst should then attempt to use other assessment tools, such as a functional analysis (i.e., experimental investigation of variables affecting the target behavior) to better understand the variables affecting the	

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		target behavior. In addressing complex behavior problems, functional assessments are often revised several times. Interviews with psychology staff indicated that staff were beginning to conduct direct assessments using ABC data sheets. At the time of onsite tour however, data from these assessments were not included in the functional assessments. The replacement behaviors identified in the functional assessments or PBSPs were functional. For example, Individual #37's inappropriate sexual behavior was hypothesized to be attention motivated, and his replacement behavior consisted of teaching him appropriate ways to attain attention from staff. Not one of the replacement behaviors reviewed, however, was operationally defined so that direct care professionals (DCPs) would be able to conduct training. For example Individual # 37's replacement behavior was defined as "eliciting attention from staff in a constructive way (e.g., completing chores, working at the workshop, participating in training, etc.)." It is unlikely that DCPs could reliably teach these replacement behaviors based on this these general instructions. Specific skill acquisition plans should be implemented for replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility, that is, they should not be treated any differently because they are part of a PBSP. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 of this report). There was some evidence that functional assessments were reviewed and modified when an individual did not meet treatment expectations. It is interesting that these examples did not include a formal functional assessment, however, they represented examples of procedural revisions as a result of a better understanding the target behavior: • In Behavior Support Plan (BSP) addendum for Individual #104 (dated 6/29/10), it was hypothesized that several recent restraints were related to a change in routine. Therefore, a change in his schedule was implemented such that his routine was more predictable. • In BSP addendum for Individual #56 (dated 4/28/09), it was hypothesized that a recent increase in aggression might have been due to DCP needing more training in implementing Individual #56's plan. These examples of modifications in the functional assessment and PBSP in response to the absence of progress or an increase in target behaviors represented an important step toward the functional use of behavioral assessment and treatment. Although there was	

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		not documentation that this practice occurred for all, or even most individual's where behavioral progress was absent (see review of progress notes in K4), it was encouraging that the process of modifying the functional assessment (i.e., attempting to understand the behavior) and implementing a treatment based on the results of that assessment, was beginning to occur at EPSSLC. In future onsite reviews, the monitoring team will be looking for documentation that functional assessment and subsequent PBSP modifications are routinely conducted when individuals' behavior does not meet treatment expectations.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The annual summaries of psychological assessments were not based on current, accurate, and complete clinical and behavioral data (see K5 and K7) and therefore this provision item was rated as noncompliance. At the time of the onsite tour, EPSSLC did not conduct intellectual/cognitive assessments or adaptive assessments. They did complete annual psychological updates for some, but not all, individuals. The updates reported a combination of historical data (e.g., intellectual and adaptive scores) and some new assessment data (e.g., review of behavioral and medical status). A spreadsheet specifying the dates of psychological assessments for each individual at EPSSLC indicated that 69 individuals at the facility did not have psychological assessments.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	As indicated in K6, psychological assessments were not completed for every individual at EPSSLC and, therefore, this provision item was rated as being in noncompliance. The facility should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Some components of the psychological assessment at EPSSLC (see K5), such as the assessment of biological, physical, and medical status were reassessed annually; however others such as intellectual and adaptive functioning were not reassessed at regular intervals. Additionally, the monitoring team expects that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update would comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. It was encouraging to learn that the most recent admission, Individual #161, had a psychological assessment update completed within the 30 day requirement for newly admitted individuals specified in this provision. Nevertheless, her intellectual and	Noncompliance

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		adaptive scores reported on the update were based on tests administered in 1995.	
K8	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.	Psychological assessments reviewed did not document the need for psychological services other than PBSPs. Interviews with staff, however, revealed that these services were often recommended in meetings such as the PST. It is recommended that need for these services be documented in the psychological assessments. Nevertheless, the facility made improvements in providing needed psychological services, but more work needed to be done before this provision item can be considered to be in substantial compliance. At the time of the baseline monitoring review, only one individual was scheduled for counseling services, and staff indicated that those sessions were irregular due to staffing issues. Further, at the time of the baseline monitoring review, no documentation of goals and progress was available. At the time of this onsite review, however, the facility had added an anger management group and a health education group in addition to individual counseling (Circles). Eight individuals participated in these services at the time of the onsite review. There was no documentation of description provided to the monitoring team regarding how these individuals were chosen and whether or not all individuals were considered for these types of services. Additionally, the services included: • A plan of service • Goals and measurable objectives • Documentation reflecting evidence-based practices • Services included in progress notes • Qualified staff (i.e., psychologists with a degree in counseling) providing the services The need for these services, however, should be documented in the individual's psychological assessment and implemented within six weeks of the assessment. Additionally, the service plan should also include: • a "fail criteria" that will trigger a review and revision of interventions to ensure that services do not continue if objective are not achieved • and a process to generalize skills learned to living, work, leisure, and other settings	Noncompliance

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		It is recommended that the facility continue to develop needed psychological services. The monitoring team realizes that this was a very new addition to services at EPSSLC and looks forward to learning about its progress during subsequent onsite monitoring visits.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	PBSPs at EPSSLC were in place for many individuals. The content of the plans, however, as indicated below, led to a rating of noncompliance for this provision item. All of the PBSPs reviewed had the necessary consents and approvals. The 33 PBSPs reviewed were in two different formats. It is recommended that the facility use one consistent format for PBSPs. There are several important components that should be included in every PBSP. EPSSLC utilized a "working plan" that represented a summary of the PBSP that was specifically tailored for implementation of the plans by DCPs. The monitoring team reviewed both documents to determine the presence of these necessary components of the PBSP. All of PBSPs reviewed included: • Rationale for selection of the proposed intervention. • History of prior intervention strategies and outcomes • Consideration of medical, psychiatric and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors (see K5). • Description of potential function(s) of behavior. • Use of positive reinforcement sufficient for strengthening desired behavior. • Strategies addressing setting event and motivating operation issues. • Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors. • Strategies to weaken undesired behavior. • Description of data collection procedures. • Baseline or comparison data. • Treatment expectations and timeframes written in objective, observable, and measureable terms. • Signature of individual responsible for developing the PBSP. On the other hand the PBSPs reviewed did not consistently contain the following necessary components of a PBSP: • Consideration of medical, psychiatric, and healthcare issues (this item was covered in some of the functional assessments reviewed). In future reviews when functional assessments are consistently included with the PBSPs, the monitoring team will review both the PBSPs and functional assessments to	Noncompliance

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		determine compliance with this provision. • Clear, simple, precise interventions for responding to the behavior when it occurs (see comments below). • Plan, or considerations, to reduce intensity of intervention, if applicable. All of the above components should be included in functional assessments and/or PBSPs. Although all the PBSPs contained interventions for responding to target behaviors when they occurred, many were not clear, simple, or precise. Instead, the descriptions in many PBSPs were unclear or complicated. Some examples are listed below. • Individual #9's PBSP (working plan) indicated that her target behaviors were maintained by getting DCPs to comply with her requests and staff attention. In the prevention section of the working plan of the PBSP, Individual #9's plan stated that "….when she appears bored or restless, offer her a variety of items to manipulate or tasks to do. If she hesitates, sincerely motivate her with a variety of options and choices to start on the activity or task." This prevention strategy of keeping Individual #9 busy working on preferred tasks was consistent with the hypothesized function of the target behavior (staff attention), however, typically, this is a very challenging activity and it is likely that not all DCPs would be able to successfully maintain Individual #9's attention with these tasks without substantially more specific and precise teaching instructions. Additionally, the prevention section of the working plan stated, "Staff must take the utmost precaution in ensuring her safety as well as denying her any attention whatsoever during such behaviors" (i.e., target behaviors). On the following page (titled How to Respond To Challenging Behavior), the working plan specified that when Individual #9 engaged in SIB, her staff should ask her what is wrong, and help to solve the problem. These seemingly incompatible interventions not only would likely increase the frequency of target behaviors, but also result in DCPs being unclear about how to respond when Individual #9 engaged in target behaviors. • Individual # 104's working plan stated, "Check your posture and your approach and ensure that it is empathic and not threatening." • Individual #79"s working plan specified a very complicated procedure that required that DCPs make false statements to Individual #79 in order to determine if she is making a false accusation. As discussed above, a critical aspect of applied behavior analysis is ensuring that interventions are based on functional assessment results. Although functional assessment reports were completed for only nine individuals at EPSSLC, all 33 of the PBSPs reviewed included a summary of the functions of challenging behaviors. In some	

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		of these plans, the intervention was clearly based on functional assessment results (e.g., Individual # 37). In many PBSPs, however, the interventions appeared to be contraindicated by the functional assessment results. The following examples were typical: • Individual #116's working plan of the PBSP hypothesized that her physical aggression was maintained by negative reinforcement (i.e., escape or avoidance of undesired activities or interactions). Her plan specified, however, that when she was physically aggressive, staff were to remove any triggers that were present. Given the fact that her aggressive behavior was thought to be maintained by negative reinforcement, it was likely that those triggers were things she wanted to escape or avoid and, therefore, this aspect of her PBSP would likely increase the frequency of her physical aggression. • Individual #108's PBSP suggested that her target behaviors might be maintained by the stimulation or change in the environment her behavior produced. Her PBSP, however, specified that when target behaviors occurred, to ask her what she wanted and to give it to her. This PBSP would likely teach her that engaging in the target behavior was the most reliable way to get what she wanted, and would likely result in an increase in the target behavior. There was no evidence in the PBSPs reviewed that they were based on individual preferences, and many were not modified based on ongoing individual behavior (see K4).	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Inter-observer agreement measures were not collected for target and replacement behaviors at the time of the onsite tour. A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for meeting the requirement of this provision item. PBSP data were consistently graphed monthly at EPSSLC. As discussed in K4, however, these data should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. They did not contain clear demarcation of changes in medication, health status, or other relevant events.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one	All staff interviewed indicated that they understood each individual's PBSP. Additionally, staff were able to explain (in very general terms) how they would implement an individual's PBSP. Observations of DCPs implementing PBSPs, however, revealed some	Noncompliance

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	year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	discrepancies between how the plans were written and how they were conducted and resulted in this provision item being rated as being in noncompliance. Examples are provided below. • During a tour of the vocational training areas, the monitoring team observed Individual #82 engage in one of his target behaviors, SIB. The DCP responded by holding Individual #82's hands and gently reassuring him. Individual #82's PBSP indicated that staff should redirect him and prompt him to use his communication book following the occurrence of SIB. Later, back at Individual #82's residence, the monitoring team asked the DCP why she had held his hands following the SIB. She replied because he wanted her to hold his hands. Not only is holding Individual #82's hands not included in the plan, but if the DCP was correct and having his hands held was in fact what he wanted, it was likely that this procedure would increase the likelihood of Individual #82's SIB in the future. • During a tour of Cottage 506, the monitoring team observed Individual #27 engage in aggressive behavior. His PBSP specified that following aggressions he should be told to stop, and attempts should be made to give him what he wants or what he wants changed (see K9 for problems with plans inadvertently reinforcing target behaviors), and encourage him to begin an appropriate activity. Following the aggression, however, the staff told Individual #27 to stop, and when his aggression and agitation subsided, began engaging him in an appropriate activity again. Although the staff's interaction arguably may have been more therapeutic than the written plan, it was not consistent with the PBSP that included asking him what was wrong and attempting to give what he wanted or what he wanted changed. EPSSLC made progress on this provision item by introducing a system to monitor and ensure treatment integrity. The integrity measure was reportedly administered 30 times each week (across different staff and all cottages). The tool involved asking staff specific questions about the PBSP, such as target behaviors, prevention procedures, and data collection. The above examples, however, suggested that a good treatment integrity measure should also include actual observations of staff implementing PBSPs. The psychology technicians collected and maintained these integrity data. In order to ensure that all staff have been trained, and integrity trends identified, it is recommended that these integrity data be maintained centrally, and the data reviewed regularly, perhaps as part of the facility's QE program (see section E above). The monitoring team did not have the opportunity to observe the integrity system, and will be looking more closely at it in future visits.	

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		Finally EPSSLC created a specific "working plan" section of their PBSPs. The working plan consisted of a summary of the functions of the target behaviors, a description of the replacement behaviors, instructions on how to prevent the target behaviors, and a section on what to do when target behaviors occurred. It was designed specifically for DCPs and was written in language staff could understand without jargon. All DCP interviewed indicated that they could understand the plans.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	All DCPs interviewed indicated that they had received training on individual PBSPs. The psychology department maintained training logs documenting staff trained, and conducted monthly integrity checks and training (see K11). The trainings were conducted by the psychologists, psychology assistants, and psychology technicians. There was not, however, a methodology for initial trainings. Additionally, there was no system in place to ensure that all staff (including relief staff) had been trained. Finally there was no systematic way to identify staff who required remedial training. To ensure that staff training is consistently effective, it is recommended that staff training procedures be standardized across the department. Additionally, the department needs to develop a more coordinated system to ensure that all staff were trained in the implementation of each individual's PBSP in order to meet the requirements of this provision item. It is also recommended that the facility identify a standard methodology for staff training that includes a combination of didactic, modeled, and in vivo strategies.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the onsite tour, EPSSLC employed five psychologists plus the director, who was a behavior analyst. She was the only member of the psychology staff who had obtained BCBA certification (see K1). Additionally, the facility employed two psychology assistants. This provision specified that the facility have one psychology assistant for every two psychologists. Therefore, the facility required four additional BCBAs and one additional psychology assistant to attain compliance with this provision.	Noncompliance

Recommendations:

1. Continue with training and supervision of psychology staff towards obtaining the BCBA certification.
2. Establish an internal and external peer review system for all psychologists writing PBSPs.

3. Expand hourly data collection to all cottages and day programs.

4. Expand the data system to include more than just frequency measures.

5. DCP input in data system development should be documented.

6. Inter-observer agreement (IOA) data should be collected, and IOA goals established.

7. PBSP target and replacement behaviors should be graphed at a frequency sufficient to promote effective decision-making.

8. The criterion for modification of PBSPs should be based on the individual's behavior.

9. Each individual's record should contain a psychological assessment that consists of an assessment of intellectual and adaptive ability and biological (or physical) status. Additionally the assessment should include a personal history as well as a screening for psychopathology and behavioral issues. Finally the assessment should identify the name of the test or measure used to make the assessment, and the date the assessment was administered.

10. All individuals with a record or assessment reflecting a behavior problem that adversely affects, or potentially affects, the life of the individual or others, should have a functional assessment completed.

11. The facility should choose one functional assessment format that includes all of the necessary components identified in K5.

12. Specific skill acquisition plans should be implemented for replacement behaviors.

13. Functional assessment and subsequent PBSP modifications should be consistently conducted when individuals' behavior does not meet treatment expectations.

14. Each individual should have a current, accurate, and complete psychological assessment.

15. Psychological re-assessments should be conducted as often as needed, but at least every five years.

16. Psychological assessments should be conducted within 30 days for newly admitted individuals.

17. Each individual's psychological evaluation should contain, at minimum:
    a. standardized assessment or review of intellectual and cognitive ability
    b. standardized assessment of adaptive ability
    c. screening for psychopathology, emotional, and behavioral issues
    d. assessment or review of biological, physical, and medical status
    e. review of personal history

18. Psychological assessments should document the need for psychological services other than PBSPs.

19. The service plan for psychological services other than PBSPs should include the following additional components:
    a. a “fail criteria” that will trigger a review and revision of interventions to ensure that services do not continue if objective are not achieved
    b. and a process to generalize skills learned to living, work, leisure, and other settings

20. It is recommended that the facility use one consistent format for PBSPs.

21. PBSPs and/or functional assessments should contain the following additional components :
    a. Consideration of medical, psychiatric, and healthcare issues
    b. Clear, simple, precise interventions for responding to the behavior when it occurs
    c. Plan, or considerations, to reduce intensity of intervention, if applicable

22. All PBSPs should be based on functional assessment results.

23. Treatment integrity data should be maintained centrally, and should contain direct observations of staff implementing PBSPs.

24. Staff training procedures should be standardized and coordinated across the department to ensure that all staff are trained, and competent, in the implementation of each individual’s PBSP.

25. Develop a standard staff training methodology that includes a combination of didactic, modeled, and in vivo strategies.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Policy and Procedure Manual for the EPSSLC Medical Department o DADS Policy#006: At Risk Individuals, dated 10/5/09 o EPSSLC Operating Instructions: Seizure Management, revised 7/2008 o DADS Policy# 09-001 Clinical Death Review, dated 3/09 o DADS Policy #09-002 Administrative Death Review, dated 3/09 o Mock Medical Emergency Drills, dated 2/07 o Clinical and Administrative Death Reviews of the following individuals: • Individual #22, Individual#101 o Records of the following 21 individuals: • Individual #1, Individual #2, Individual #3, Individual #11, Individual #13, Individual #16, Individual #17, Individual #40, Individual #46, Individual #47, Individual #54, Individual #58, Individual #61, Individual #70, Individual #78, Individual #88, Individual #100, Individual #113, Individual #119, Individual #126, Individual #178 Interviews and Meetings Held: o Ken Wiant, M.D., Medical Director o Salvador Molina, M.D., Staff Physician o Marcelita Torres FNP-C, Nurse Practitioner o Julie Moy, M.D., M.P.H., Medical Director, DADS o Sandra Delong, R.N., Chief Nursing Executive Observations Conducted: o EPSSLC medical clinic o Cottage and dorms o Day services areas o Risk level and heath status meeting
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Overall, individuals received a wide variety of healthcare services. Policies and procedures were needed to guide the medical staff in the delivery of those services. EPSSLC was found to be in noncompliance with

	this provision of the Settlement Agreement because a number of areas of weakness existed in the medical services practice at the facility as indicated below in this section of the report. Medical care was provided by a staff that included a full-time medical director, a staff physician, and a nurse practitioner. The medical director had been employed at the facility for six years and until January 2010, was the only provider of primary care services. His role as the sole provider of care resulted in a lack of involvement in many areas that require the attention of the medical director. Integration of medical services will require that the medical director be involved in a vast array of programmatic activities outside of the usual clinical care responsibilities. In January 2010, the facility contracted with a family nurse practitioner who worked four days a week. She was supervised by the medical director. On 6/1/10, the facility hired an internal medicine trained physician who was designated to assume the position of the medical director on 11/1/10 when the current medical director retires. The transition of patient care was ongoing and no definite caseloads had been established for either of the two new providers. The nurse practitioner completed the annual medical summaries and performed assessments during sick call and as needed. The staff physician was conducting sick call and gradually assuming a caseload.

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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 state policy for this provision was not in place at the time of the onsite review. Comments in this section are based on current generally accepted professional standards of care as proposed in the Healthcare Guidelines, 2009. Overall, a variety of appropriate medical services were provided to the individuals at EPSSLC. As noted below, however, a number of areas of weakness exist in the medical services practice at the facility and, therefore, this provision item was rated as being in noncompliance. **General Medical Care and Documentation** <u>Annual Medical Summaries</u> The Annual Medical Summaries (AMS) were based on a standardized template consisting of nine sections: o Problem lists o Past medical history o Personal medical concerns o Osteoporosis risk factors assessment o Interval history since last physical examination o Medications, allergies, diet, data review	Noncompliance

#	Provision	Assessment of Status	Compliance
		- Lab, immunization, x-ray, vision, dental, hearing, consultations, and immunizations - Physical exam - Discussion of significant problems and recommendations The first page of each AMS contained active and inactive problem lists. Active problems were frequently recorded in the inactive problem list. As an annual assessment document, the problem lists were not updated. The medical histories contained some good information, but they were not comprehensive. They did not include family, social, and childhood histories. Each AMS referenced a permanent past medical history in the record. This document was found in only a few of the records reviewed. Functional assessments were not included in the AMS. The final component of the AMS was the discussion section. Generic statements related to problems and plans were included in all of the AMS documents reviewed: " Patient is being maintained on chronic medications that have been effective in stabilizing his major medical problems including panhypopitiatism, diabetes insipidus, osteoporosis, hyperlipidemia, hypothyroidism, hypogonadism, gastritis, seizure disorder, constipation, and diabetes mellitus." The discussion section did not include a summary of the problems and the corresponding plan of care for each problem. <u>Active Problem List</u> Active Problem Lists (APL) were not found in any of the records reviewed, independent of the Annual Medical Summary. Many of the records reviewed retained a formal APL that was last updated 15 to 20 years ago. <u>Integrated Progress Notes</u> The SOAP format was utilized for progress notes. The notes were consistently dated, timed, and signed. Objective data almost always included a BMI, but vital signs were frequently not included in the note, even when relevant to the problem being addressed. Quarterly notes were not present in the records reviewed. Lab reports and x-rays were consistently reviewed, initialed, and dated. Progress note entries related to abnormal findings were inconsistently done.	

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		<u>Physician Orders</u> Physician orders were written in accordance with the pharmacy and therapeutics guidelines of the health care guidelines. Orders were routinely dated, timed, and signed. Most orders included a diagnosis or indication for the medication. Monitoring parameters were not seen in the records reviewed. The physician order sheets in the records reviewed did not include a header with the full official name of the facility or the name of the PCP. The header included the name and date of birth of the individual. <u>Consultations</u> Individuals were frequently referred to providers for consultation and diagnostic testing. There were several issues related to the consultation forms: • The date of request was blank on every form in the records reviewed. This made it difficult to determine if a consult occurred within an appropriate timeframe. • The reason for the consult was almost always vague. Requesting consult for "Eval" was seen on many of the consultation request forms. • The consultations were reviewed, signed, and dated promptly following receipt. Corresponding documentation in the progress notes, however, was not consistent. <u>Disease Management</u> Diabetes • The records of two individuals with a diagnosis of diabetes mellitus were reviewed. Some of the basic elements of diabetes management were not evident in the limited record reviews. o Individual#16: The individual was treated with insulin and blood glucose was monitored frequently. Diabetes was fairly well controlled based on HbA1c levels. Urinary microalbumin was measured and was negligible. Eye exams were completed regularly. The last documented podiatry exam was in 2008. o Individual#113: Individual was treated with oral agents and insulin. There was frequent monitoring of blood glucose and renal function, but control was poor based on multiple elevated HbA1cs. The individual was on an ACE inhibitor, but documentation of urinary microalbumin was not in the record. Eye exams were documented, but recent podiatry exams were not. GERD • Eleven of the 21 individuals reviewed had a diagnosis of GERD. While all	

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		received medical management (medication), there was little documentation by the physician of other aspects of disease management regarding this condition. For example, physicians at EPSSLC documented that GERD was being treated with medication, however, rarely did the annual summaries address issues of dietary modification, positioning, and head of bed elevation. These are the standard reflux precautions. A through medical plan should include those as well. Hypertension • One individual had a diagnosis of hypertension. Appropriate medical management was provided. Osteoporosis • A diagnosis of osteoporosis was found in 57% of the individuals whose records were reviewed and osteopenia was diagnosed in 29% of the individuals. Bone mineral densities were completed for every individual included in the record reviews. Vitamin D levels were checked for every individual and supplementation was provided when low. Calcium and Vitamin D were prescribed for all persons with osteopenia or osteoporosis. Evidence of medical management was present in all records. Bone mineral densities were re-checked for most individuals at five year intervals. Bowel Management Nineteen of the 21 individuals whose records were reviewed had a diagnosis of constipation. The facility did not have any formal policy, procedures, or guidelines related to bowel management. There was also no aggregate data related to the use of acute interventions within the facility. Physician documentation related to bowel management was infrequent, even when individuals were encountering difficulty with bowel management. There was no discussion in the AMS of the risk for bowel irregularities or a specified plan of care. The charts reviewed indicated that most persons received either the same or very similar bowel management programs consisting of a regimen of lactulose, dulcolax, and bisacodyl suppositories. Fluid management, activity, use of constipating drugs, dietary issues, and other factors important in bowel management were not discussed in medical documentation. **Routine and Preventive Care** Record reviews indicated that individuals had received preventive care. There were no	

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		written guidelines in place to determine the types of preventive services an individual received or the frequency that those services should be provided. There was no formal process for tracking the provision of preventive care procedures. The medical director maintained a database on his computer. The database contained information related to colonoscopy and pap dates, PSA levels, and osteoporosis. While the database may have provided some important information, its usefulness was limited by several factors: • The database did not provide any cues for when preventive care was due. • The printouts from the database were difficult to follow. • The ages in the database in most instances were the ages entered at the time of original data entry in 2005. Users would need to remember to add five years to the age. • The database was not shared with other members of the team. It was on occasion sent to the chief nursing officer. • The database was maintained by the medical director and was not a part of the facility's quality enhancement program (see section E of this report). Immunizations The AMS documented administration of DT, influenza vaccine, Hepatitis B vaccine, and pneumovax, and this was found in all of the records reviewed. This information was readily accessed in the annual assessment. Documentation of varicella and MMR status was less consistent. Screenings The facility did not have any operational procedures, guidelines, or prevention/disease management flow sheets to guide the provision of preventive care. An assessment of compliance was based on the requirements of the Health Care Guidelines. • Audiology evaluations and vision assessments were consistently documented in the records reviewed. • Dental assessments were consistently documented. Additional information on dental care is provided in Section Q. • Mammography was completed for many of the females whose charts were reviewed. • Pelvic exams and pap smears were frequently deferred with explanations such as "not sexually active." There was no discussion or documentation of a risk benefit analysis related to this preventive care requirement. • Colonoscopies were done on several individuals whose records were reviewed.	

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		• PSAs were frequently documented. • Osteoporosis screenings were documented in all records reviewed. <u>Risk identification</u> Each AMS included a risk assessment for osteoporosis. Although every individual reviewed was screened for osteoporosis, there was little discussion related to mitigation of the risk factors. There was no discussion in the document of other significant risk factors such as cardiovascular disease, bowel obstruction, significant weight change, diabetes mellitus, and aspiration. **Acute Medical Problems and Emergency Care** <u>Management of acute illness</u> Overall, there was evidence that the medical staff addressed acute problems and the interventions were often adequate. There were numerous examples of care which involved either a failure to notify the MD or inadequate MD follow-up after the initial assessment: • Individual #1: 2/24/10: A routine CBC returned with a platelet count of 69,000. MD checked "no action necessary" box. The progress notes contained no explanation of thrombocytopenia and no plan for follow-up for a potentially serious condition. • Individual #11: 7/11/10 at 1200: Nursing notes documented that "DCS reported individual was very pale. Vital signs: temp 97.5, BP 116/68, HR 115, RR 18, oxygen saturation on room air 94%. Skin noted to be cold but DCS stated she is always cold. No respiratory distress noted. Will notify clinic nurse via email. Continue to monitor." On 7/13/10 (1545): The individual was seen by the FNP due to reports of paleness. Progress notes documented that lips, conjunctiva, and nail beds were pale. Vital signs were temp 98.8, BP 110/82, HR 118-122, and oxygen saturation on room air 92%. There was no respiratory difficulty and the lungs were clear. Rectal exam produced stool that was questionably heme positive. The assessment was pallor, tachycardia, and anemia. The plan was to check a CBC, iron studies, metabolic panel, B12, and UA C&S. At 1830, the nursing entry indicated the on-call MD was notified of labs (Hb 3.9/Hct 15.6) and ordered to be transferred to the emergency department via a state vehicle. The individual was admitted, transfused with four units of packed red blood cells, and underwent colonoscopy and EGD. The discharge diagnosis on 7/17/10 was GI bleed. *There was no documentation that the MD was notified of abnormal findings on	

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		7/11/10. On 7/13/10, the presence of pallor, tachycardia, and heme positive stools should have been cues to consider transfer for further evaluation. • Individual #178: 6/15/10: The individual was seen by the MD due to generalized weakness, upper extremity weakness, and lethargy. The plan was to obtain a metabolic work up, MRI, and CT scan. Follow-up documentation on 6/16/10 by the MD noted that the individual was clinically better. HCTZ was added for BP control. On 6/18/10, the individual had an EGD done. On 6/22/10, the MD decided to transfer to the local hospital due to worsening weakness. The individual was admitted and diagnosed with C3-C4 spinal cord compression requiring surgical intervention. *This individual had a history of weakness and lethargy. There was no MD assessment on 6/17 and 6/18. • Individual #113: 6/21/10: The individual was evaluated by the MD due to cough and green sputum. Vital signs showed pulse oximerty of 92% on room air, heart rate 108, and temperature 98.2. The assessment was acute bronchitis and altered mental status. The plan was to check labs and chest x-ray. The next MD note was on 6/25/10. The individual was transferred to the hospital on 6/25/10. • Individual #40: 5/13/10: The individual was seen by nurse practitioner for follow-up of abdominal pain. The assessment was abdominal pain and constipation and the plan was to continue current care. On 5/21/10, the individual returned from Dr. Vogeleweed's office with a diagnosis of UTI. Nursing documentation noted that the rectal exam by Dr. Vogelweed revealed impaction. Nursing documentation was "fluids need to be increased for continued constipation." Saline enemas were given. *There is no physician note that addressed this problem and no changes were made in bowel management. • Individual #88: Seen by the MD on 5/13/10 at 1110 for red area on left breast. Physician documentation noted that the infection control nurse would open the pustule to obtain a culture in the morning. Another individual in the same cottage had a diagnosis of MRSA. The plan was to start antibiotics after the infection control nurse opened the pustule. The assessment did not contain vital signs or temperature in this individual with an infectious process. On 5/14/10, the pustule was opened by the nurse and a culture submitted. The MD note on 5/14/10 indicated treatment with Bactrim and follow-up in four days. The individual also had a diagnosis of UTI. The MD note on 5/18/10 indicated the abscess was healing well and follow-up in two weeks was needed. The culture was negative for MRSA. The note called for follow-up in one week for toe pain. *There was no explanation for the MD's decision to wait until the next day for the nurse to aspirate a pustule and begin antibiotic treatment.	

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		Hospitalizations and transfers The records reviewed contained numerous accounts of individuals who were transferred to local hospitals for hospitalization or emergency department evaluation. The trend towards inadequate follow-up, noted above in acute care examples, persisted in post-hospital notes. There did not appear to be any requirement for continuous follow-up upon return to the facility. The following are examples of inconsistent medical follow-up upon return to the facility: • Individual #47: 7/12/10: Individual was seen by MD for right knee redness and was started on antibiotics for a diagnosis of cellulitis. She was seen again that day for pain assessment and was referred to the local Emergency Department for evaluation of a possible septic joint. The MD assessed the individual on 7/13/10 following return to the facility. The next MD note was 7/15/10 and indicated that the plan was to continue antibiotics and follow-up next week. On 7/21/10, the MD note documented resolution. • Individual #40: MD saw individual for URI on 9/30/09. Nursing notes documented a history of vomiting undigested food at 2200 with a plan to monitor. On 10/1/09 at 0215, the individual was noted to have an O2 saturation of 80% on room air. Oxygen was started. At 0230, the individual was wheezing and had an O2 saturation of 91% on three liters of oxygen. The nurse contacted the on-call MD who ordered that individual be transferred to local ER. The individual was admitted to the hospital with a diagnosis of aspiration pneumonia and was discharged on 10/3/10. An MD assessment was completed on 10/4/10 and follow-up scheduled in five days. Progress note documentation provided evidence of communication between medical director and attending hospital MD. Code E The facility maintained a system of responding to medical emergencies. Mock drills were conducted. The tracking logs for this activity were not made available. The medical director and staff physician both reported that there were no post-code critiques and no formal meetings to address deficiencies found. This activity should occur following drills. All of the medical staff maintained ACLS certification. **Seizure Management** Ninety-one individuals had a diagnosis of seizure disorder. In the majority of the cases, the seizure type was not classified. The facility utilized the services of a contract epileptologist. The medical director reported that neurology clinic was held once a	

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		month for approximately three hours during which time 10 to 11 individuals were seen. The facility did not have a comprehensive seizure management program in place. The seizure management policy focused on care of an individual during a seizure. A comprehensive seizure management policy should include information on 1. classification of seizure disorder, 2. goals of treatment, 3. drug selection, 4. frequency of clinic visits, 5. requirements for EEG, 6. AED side effect monitoring, and 7. and management of status epilepticus. The current policy did not provide information to staff on seizure classification and did not provide a true definition of status epilepticus (timeframe). The facility did not have processes in place to track data to determine the overall quality and effectiveness of the seizure management. The use of diastat was tracked, but there was no process in place to track key seizure data such as: 1. the number of individuals prescribed two, three or four drugs, 2. the number of individuals on monotherapy, 3. the number of individuals with a history of status, 4. the number of individuals with refractory seizure disorder, 5. the number of persons with refractory disorder who had been evaluated for alternative treatments such an VNS, and 6. the number of persons who have been seizure free for 5 years. The polypharmacy list reviewed with the pharmacy director had not been updated since March 2009. In several instances, individuals had a psychiatric diagnosis in addition to a seizure disorder. Progress notes commented on some issues, such as the use of an AED for behavior, or the possibility of amantadine causing behavioral problems. There was, however, no formal mechanism to integrate neurology and psychiatry, such as a neuropsychiatric clinic. Almost all of the seizure clinic notes made some reference to the individual's grooming, alertness and behavior. The notes did not address other important quality of life issues. Seizure reports found in the records were often incomplete and illegible due to small print. Two documents entitled "Seizure Record" were found in some records. The document with a revision date of 6/10 provided a more detailed description of	

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		seizure activity. Both appeared to have been used at the facility.
		
		Staff received competency based training on seizure management. While staff did receive training on the use of the VNS magnet, it was not competency based. There was also no standardization for maintaining the VNS magnets in the cottages. It was observed in home 507, during dinner time, that staff searched several minutes prior to locating the magnet for one individual (in response to a question from the monitoring team).
		
		The onsite clinic notes documented that care included monitoring of labs and drug levels. It was also evident that drug changes were instituted slowly and carefully. Recommendations were often very specific regarding the titrations. The onsite clinic notes showed that the epileptologist reviewed data, including seizure reports and medication profiles. Several notes also specifically addressed the goal of monotherapy. Of the 11 charts reviewed, five individuals were on monotherapy.
		
		In the records reviewed, there were two individuals in long standing remission who remained on drugs. Further explanation may have been evident in older records, but not in the active records for Individual #16. Individual #13 had no recent neurology assessments, but remained on two drugs for seizure disorder. This individual had extremely challenging behavior and was being referred for neurology evaluation. Overall, the decision to taper drugs to extinction and to move to monotherapy appeared to have been given appropriate consideration. The following examples are from records reviewed and include AED drug regimens and the most recent clinic assessments and recommendations:
		
		• Individual#16
		  o Meds: Valproic acid
		  o 5/29/09: Ass/Recc: Sustained remission.
		
		• Individual #1
		  o Meds: Rufinamide, valproic acid
		  o 7/7/10: Ass/Recc: Intractable secondary generalized epilepsy due to LGS. Continue meds and RTC 3 months.
		
		• Individual #3
		  o VNS
		  o Meds: Rufinamide, lamotrigine, phenobarbital
		  o 7/7/10: Ass/Recc: Intractable epilepsy -VNS adjusted; titrate lamotrigine up; RTC 1-2 months.	

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		• Individual #11
		  o Meds: Lamotrigine
		  o 11/4/09: Ass/Recc: Epilepsy in sustained remission; attempt to convert to lamotrigine monotherapy.
		
		• Individual #13
		  o Meds: Oxcarbazepine and lamotrigine
		  o 2006: Inactive diagnosis with long standing remission.
		
		• Individual #40
		  o Meds: Carbamazepine
		  o 6/10/10: Ass/Recc: Check carbatrol level and RTC 2 months.
		  o 3/13/10: Uncontrolled epilepsy, recently in remission; increase carbatrol and RTC three months.
		
		• Individual #47
		  o Meds: Levetiracetam
		  o 4/7/10: Ass/Recc: No seizures since 12/09. Continue current AED regimen
		  o 12/2/09: Hyponatremia secondary to trileptal; taper off trileptal.
		  o 10/14/09: "On amantadine for 'EPS'…..specifics unclear to me, but this could be contributing to her behavior." PCP reviewed note on 10/14/09. Progress note indicated that PCP would consult psychiatry on the issue of amantadine.
		
		• Individual #61
		  o VNS
		  o Meds: Lamotrigine
		  o 7/1/09: Ass/Recc: Epilepsy in sustained remission. Continue current treatment and return in six months.
		
		• Individual #78
		  o Meds: Carbamazepine, lamotrigine, topiramate
		  o 10/8/08: Psychiatry recommended carbatrol for behavior.
		
		• Individual #100
		  o Meds: Rufinamide, lamotrigine, and levitricam
		  o 5/5/10: Persistent adult LGS; trial of rufinamide. Anticipate medication simplification.	

#	Provision	Assessment of Status	Compliance
		• Individual#1126 o Meds: Lamotrigine, rufinamide o 7/7/10: Recent high frequency of seizures and flurries, slowing somewhat in last few days noted. o Ass/Recc: Refractory seizures consistent with LGS. Avoid dilantin and monitor med compliance; RTC one month.	
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 facility had not established a medical review system and, therefore, this provision item was found to be in noncompliance. Comments regarding one type of medical review done at the facility, however, are presented below. **Mortality Reviews** The mortality review system at EPSSLC involved three action steps per policy: 1. Within five working days of notification of death, the physician completes a death summary for the record. 2. Within 14 working days of notification of death (45 with autopsy) the clinical death review committee meets. 3. Within 21 calendar days of completion of review by the clinical death committee (52 with autopsy) the clinical death review committee will forward a report to the administrative death review committee. This goal of the mortality review was to provide a comprehensive review of clinical care and operational procedures that may have affected the overall care of the individual. Recommendations for correction actions were to be made when appropriate. Each review committee required the participation of an external representative. • Individual#22 o Date of death: 1/24/10 o Clinical death review: 6/18/10 o Administrative death review: 7/13/10 • Individual #101 o Date of death: 1/6/10 o Clinical death review: 6/6/10 o Administrative death review: 7/13/10 For both death reviews, the required participants were present with one exception. There was no external physician participant.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Recommendations were generated from both reviews. The system for following up on recommendations, however, was unclear. At the time of this onsite monitoring review, there were corrective actions that had not been implemented.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility did not have a medical quality improvement process in place at the time of the review.	Noncompliance
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.	This provision item referred to the Healthcare Guidelines that provided the framework for the standards of medical care to be provided by the facility. Medical policies based on these guidelines were in development.	Noncompliance

Recommendations:

1. The facility must maintain adequate medical staffing. A fulltime medical director is needed in order to implement and monitor the systems that must be put in place. If the medical director maintains a caseload, it should be limited. There must be medical representation in the various processes occurring at the facility. This was currently not occurring.

2. Policies and procedures must be developed to guide the provision of medical care.

3. Quarterly summaries of each individual's status should be done. This can be accomplished without additional documents by generating a health profile that contains a problem list and additional information, such as current medications and diagnostic studies. This document is updated with changes as they occur and is reproduced quarterly.

4. The physicians must start to provide information to the consultants that is relevant to the question or intent of the consult.

5. A bowel management program is needed. This should focus on important aspects of bowel management including fluid administration and positioning. Individuals with bowel management problems should undergo appropriate diagnostic testing when necessary.

6. Preventive health care guidelines should be implemented that provide direction to physicians on the schedule of health prevention. These guidelines should take into consideration the special needs of the individuals supported. A thoughtful risk benefit analysis should be documented when the decision to deviate from a standard of care is made.

7. Disease management and prevention flow sheet should be implemented and available in the records.

8. Guidelines need to be implemented and enforced on the follow-up of persons with acute medical problems and those returning from the hospital.

9. A comprehensive seizure management policy should be developed. This policy should include the requirements for medical management, training, and response to seizures and status epilepticus. It should also specify what elements of care will be monitored and how that will be done.

10. A medical quality improvement program is needed. Measures of medical quality must be determined and should include process and outcome measures that are appropriate for the individuals being supported. Once determined, data should be collected and analyzed, and corrective actions taken when necessary. This process should integrate into the facility's quality improvement program.

11. Ensure that the mortality review process is implemented within the timelines. A log of corrective actions generated from the reviews should be maintained. The persons responsible for implementation and follow-through should be clearly designated.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Active Record Order & Guidelines o Map of facility o An organizational chart, including titles and names of staff currently holding management positions. o List of individuals admitted in the last six months o New staff orientation agenda o For the Nursing Department, the number of budgeted positions, staff, unfilled positions, current FTEs, and staff to individual ratio o EPSSLC Home Descriptors o EPSSLC Nursing Policies & Procedures o EPSSLC QE/QA Plan o EPSSLC Staffing Action Plan o EPSSLC Medication Bin Action Plan o Seizure management form (new) o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due)dates o Nursing staffing reports for the last six months o The last six months, minutes from the following meetings: Infection Control, Department of Nursing, Pharmacy and Therapeutics, Medication Error o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS o Training curricula on infection control including training materials o Infection control monitoring tools o Medication pass assessment tool o Emergency competency check list o Job description – Nurse Educator/Hospital Liaison o List of individuals status re: advance directives o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o List of individuals who have seen a podiatrist in the past year (included dates of appointments and whether or not appointment was kept) o List of individuals who have seen gynecologist and/or had a pelvic examination/PAP within the past three years (included dates of appointments and whether or not appointment was kept) o Individuals #115's SLP evaluations after 6/14/10

	- Medication administration schedule - Resident list for HST and Skin Integrity meetings - Records of: - Individual #18, Individual #24, Individual #155, Individual #59, Individual #1, Individual #2, Individual #104, Individual #111, Individual #69, Individual #157, Individual #73, Individual #115, Individual #184, Individual #78, Individual #83, Individual #118, Individual #94, Individual #97, Individual #52, Individual #54 Interviews and Meetings Held: - Opening meeting re: Major Milestones and Accomplishments Since 1/1/10 (7/19/10) - Medication Error Meeting (7/20/10) - Health Status Meeting (7/21/10) - Staff nurses (LVNs and RNs on Dorms A, B, C and Cottages 506, 508, 509, 511, 512, 513) - Chief Nurse Executive, Sandy DeLong, and Nursing Operations Officer, Mary Ann Clark - Quality Assurance Nurse, Elaine Lichter - Hospital Liaison/Nurse Educator, Angela Guerra - Nurse Recruiter, Nedia Daniels - Infection Control Nurse, John Chea - Director of Pharmacy Services, Amista Salcido Observations Conducted: - Medication Administration (Dorms A and C, Cottages 506, 509, and 512) - Medication Counting Procedure (Cottages 506 and 509) - Enteral Feeding (Dorms A and C) - Nursing Shift Report (Dorms A, B, and C) - Treatment/Wound Care (Dorm C)
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Although EPSSLC had been undergoing significant change and faced almost daily challenges in communicating and enforcing expectations for performance improvement, as noted in the baseline monitoring review, EPSSLC's nursing staff members were caring, compassionate, and hard-working nurses who were dedicated to carrying out the facility's philosophy as noted by the facility director during the opening conference of the week of the monitoring visit, "…to provide the best care we can for the individuals." During the conduct of this review, 20 individuals were visited, and their records were reviewed. In general, record-keeping practices were improved from the baseline monitoring review. Records were organized,

	and nurses' notes were usually in the DAP (Data, Analysis, Plan) format. There was ample evidence across the 20 individuals reviewed that the individuals' physician was notified of significant changes in their health status and needs, and/or when they needed to be "put on the clinic list" and seen, usually within less than 24 hours, by their physician or nurse practitioner. The individuals' physician and/or nurse practitioner were usually notified of individuals who had changes in seizure activity, mental status, behavior, injuries, and illnesses (e.g., vomiting, diarrhea, elevated temperature). There was also some evidence, in the shift reports, that nurses documented and also verbally communicated some changes in individuals' health status to each other during the change of shift report. Observations of medication administration were conducted on Dorms A and C and in Cottages 506, 509, and 512. During all observations of medication administration, nurses properly washed and disinfected their hands prior to medication administration and between individuals; they identified the individuals receiving medications; they adhered to the accepted standards of medication administration; and they ensured individuals' privacy and dignity. As noted in EPSSLC's baseline review, however, the facility continued to implement a system of medication administration and reconciliation that led to medication errors and placed an overwhelming demand on the time and attention of staff members including, but not limited to, nurses, pharmacists, managers, and administrators. For any one individual at any one point in time, there were anywhere from one to several MARs (Medication Administration Records) with various time frames that referenced both current and discontinued medications, with many typed, crossed-out, handwritten entries. The MARs were confusing, difficult to decipher, and impossible to reconcile with the medications on hand (i.e., the medications in the bins). The review of 20 individuals' MARs for May 2010 and June to July 2010 revealed problems of omissions and/or discrepancies in the MARs of 15 of the 20 individuals reviewed. These omissions and discrepancies included many missing entries for anti-seizure medications, anti-hypertension medications, bowel medications, antibiotics, PPIs, psychotropic medications, sleeping pills, vitamins and supplements, enteral feedings, vital signs, blood-sugar levels, and topical ointments/creams. All 20 individuals reviewed had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner. Notwithstanding these positive findings, problems were noted with the conduct of nursing assessment, diagnosis, planning, implementation of planned interventions, and evaluation of plans. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. In 17 of the 20 records reviewed, nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. All 20 individuals reviewed had some of their health needs and risks referenced by Health Management

	Plans (HMP) and Acute Health Care Plans (ACP). These plans were developed by their RN case manager in response to identified health needs/risks and/or significant changes in health status. The forms, processes, and plans in place at the time of the review, however, had many problems, and they were in dire need of complete review and revision in order to promote progress toward the achievement of the provisions of the Settlement Agreement. It was clear that a large part of the problems noted in the HMPs and ACPs were associated with the problems noted in nursing assessments and nurses' identification and follow-up to significant changes in individuals' health status and needs. At EPSSLC, there were a number of monitoring efforts underway within the Nursing Department and across the facility. Within the Nursing Department, there were differences in how performance expectations were communicated and in opinions over how goals and objects were to be achieved. Even so, there was one thing in common, that is, that all nurses were committed to providing the best care they could. They continued, however, to need additional support and training, and to be reminded that they were an important part of the solution.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Although EPSSLC was making progress towards meeting this provision item, a rating of noncompliance was made because of the frequent and regular absence of consistent identification of health care problems, implementation of interventions, and appropriate follow-up to resolution by the nursing department. During the conduct of this onsite monitoring review, 20 individuals were visited, and their records were reviewed. In general, record-keeping practices were improved from the baseline monitoring review. Records were organized, and nurses' notes were usually in the DAP (Data, Analysis, Plan) format. It was a rare occurrence to find a record note that was illegible, improperly signed and dated, and/or not designated as a late entry, when/if needed. There was ample evidence across the 20 individuals' reviewed that their physician was notified of significant changes in their health status and needs and/or when the individuals needed to be "put on the clinic list" and seen, usually within less than 24 hours, by their physician or nurse practitioner. The individuals' physician and/or nurse practitioner were usually notified of individuals with changes in seizure activity, mental status, behavior, injuries, and illnesses (e.g., vomiting, diarrhea, elevated temperature). There was also some evidence in the shift reports, that nurses documented and also verbally communicated some changes in individuals' health status to each other during the change of shift report. This process, however, was in need of improvement in order to become a reliable method of communicating all significant changes in the individuals' health status from one shift to the next. For example, during the observation of one of	Noncompliance

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		these reports, it was noted that the information relayed from one shift to the next was limited to a less than five-minute report of the results of individuals' blood sugar tests, numbers of "head drops" and/or other seizures, and instances of injury reports. Clarification of the expectations for what information must be communicated during shift to shift reports is recommended. Also, use of a structured form/format for this exchange would help ensure more complete presentation, clearer communication, and better participation in the process. Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Across all 20 individuals reviewed, documentation of Integrated Progress Notes failed to ensure that nurses were consistently documenting health care problems and changes in health status, adequately intervening, and appropriately recording follow-up to problems once identified. Numerous examples from this sample indicated the seriousness of this problem at EPSSLC: ▪ There was no documented nursing assessment or follow-up care subsequent to Individual #18's 7/17/10 emergent clinic treatment of self-inflicted trauma to his face and lips. There was also no documented nursing follow-up to Individual #18's receipt of Dulcolax suppository to treat his constipation and fecal impaction. ▪ On 7/14/10, Individual #24 fell and hit the left side of her head, sustaining a bruise to her left temple area. Although she was placed on "HIP" (Head Injury Protocol), there was no documentation of neurologic checks. In addition, on 7/15/10, Individual #24's nurse noted that she had "no abnormal neurologic status," but there was no clarification of explanation of this vague assessment. ▪ On 5/4/10, Individual #155's physician ordered an antibiotic to treat her urinary tract infection. There were no nursing assessments documented regarding Individual #155's signs/symptoms of urinary tract infection, no nursing notes regarding her receipt and response to treatment, and no nursing follow-up for over six days until 5/11/10 when her nurse noted that an "ACP (Acute Care Plan) initiated regarding [Individual #155's] risk for acute pain secondary to UTI and DCS in-serviced." ▪ On 5/18/10, Individual #59's nurse noted, "Possible bleeding from [his] penis – underwear and toilet." There was no documented nursing assessment or follow-up to this significant finding. ▪ On 7/1/10, the nurse noted that Individual #59 had a seizure and was given Diastat. According to his nurses' note, "DCS advised to take vital signs in 30 minutes. Keep in bed. Observe for further seizure activity." There was no documented nursing assessment or follow-up to his seizure and no other nurses'	

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		notes were entered in his record until 7/12/10 when he vomited after eating lunch. On this occasion, Individual #59's nurse obtained his temperature and oxygen saturation, and although the nurse indicated that he or she would "continue to monitor [him]," there was no documented nursing assessment or follow-up to his change in health status. ▪ For most of July 2010, Individual #1's nurses noted that her oral intake had decreased and her meal refusals had increased. Nursing notes indicated that Individual #1 was provided bolus enteral feedings, but failed to provide any assessment of this significant change in her health status. Notably, Individual #1 lost over 19 pounds in six months. ▪ On 7/20/10 and 7/21/10, Individual #2 was extremely lethargic and exceedingly difficult to awaken. There were no nursing assessments of her change in mental status. In addition, although Individual #2's lethargy was clearly evident to her nurses (as well as to the monitoring team), she was administered her daily dose of lorazepam 2 mg, which was prescribed to treat her "agitation and anxiety," none of which was apparent on 7/20/10 and 7/21/10. ▪ Individual #2's Integrated Progress Notes repeatedly reference her significant changes in GI status (e.g., recurrent loose stools and vomiting), but there were no nursing assessments of her change in health status, except for recording the frequency with which Individual #2 suffered these episodes. ▪ On 7/19/10, Individual #111 was prescribed Bactrim and ultrasound of her bladder and renal system for "recurrent urinary tract infection." Individual #111's nurses noted that she received her medication as ordered, obtained one set of vital signs, and encouraged the DCS (Direct Care Staff) to push fluids. Individual 111's nurses, however, failed to document a nursing assessment of the color, odor, amount, and frequency of her urine and/or her tolerance of and response to antibiotic treatment, as indicated by her plan. ▪ On 6/17/10, Individual #111 was prescribed Ciloxan ophthalmic drops for "eye infection." Individual #111's nurses noted whether or not her eyes were red/crusty, but they did not document a complete assessment of her eyes, provision of lid hygiene, response to treatment, teaching/reinforcing hand washing and prevention of transmission of infection, and so forth. Rather, Individual #111's nurses noted, "[She is] tolerating [eye drops] well even though she puts up a good fight." ▪ For over a month, Individual #157 frequently complained of tooth pain – sometimes on the left side and sometimes on the right side of her jaw. According to her nurses' notes, she frequently refused to open her mouth to permit an oral examination. Notwithstanding Individual #157's refusal to open her mouth, there were no other steps taken by her nurses to assess her change in oral health status. For example, there were no documented attempts by Individual #157's	

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		nurses to assess whether or not her pain was associated with eating/chewing, affected by hot/cold, or relieved with use of analgesic. Further, there were no documented attempts by her nurses to schedule an appointment for her to be seen by the dentist. ▪ On 5/30/10, Individual #157's nurse noted that she "had another emesis" and that her temperature was 100.3. Individual #157's nurse notified the campus RN who "stated she would come and assess her and call the doctor." One hour later, the campus RN noted the following: "Individual refused meals x2. Emesis x2 today. Temperature increased to 101 in AM. Just showered. Temperature 97.6. States feels fine. Will check on her in an hour. Continue to monitor." Individual #157's RN failed to perform and/or document a complete assessment of Individual #157, and within the hour, her condition markedly deteriorated. At Individual #157's physician's request, she was transported to the emergency room due to elevated temperature (101.9), tachycardia (pulse=134), and decreased oxygen saturation. ▪ On 7/12/10, Individual #73's nurse noted that she had not moved her bowels in three days. The results of Individual #73's nurse's examination revealed that she had a "hard impaction." A Dulcolax suppository was administered, and although "results [were] pending," there was no follow-up nursing assessment or note regarding the outcome of the intervention to address Individual #73's change in health status. ▪ It was very well documented in Individual #73's record that she had frequent episodes of crying, the reason for which was apparently not well understood by her caregivers. According to Individual #73's Integrated Progress Notes, in response to her crying episodes, her nurses administered Tylenol for "possible pain," and if/when that was not effective, Ativan was also given. What was not documented, however, was Individual #73's nurses' assessment of her "possible pain" and what/ if any changes in her health status occurred as a result of the administrations of Tylenol and/or Ativan. ▪ On 6/16/10, Individual #115's DCS reported to his nurse that he had explosive diarrhea, urinated on the floor, was lethargic and leaning to one side, had continuous head drops, and was foaming at the mouth. According to Individual #115's nurse's note, he or she obtained his vital signs and noted, "Diminished to lower lobes and left upper lobe (sic)…Lying in bed with eyes closed." There were no other notes, assessments, or indications that any actions were taken by his nurse until over 12 hours later when his nurse noted, "Awake and alert x2. BS present x 4 quadrants. Abdomen soft, not distended. Provided stoma care. Tolerating feeding and med well. Lying on bed with no signs/symptoms of distress. Will continue to monitor." There were no complete nursing assessments, no timely follow-up, and no interventions to address Individual #115's significant change in health status.	

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		▪ On 6/22/10, Individual #78's nurse noted that the individual had not moved her bowels in three days. According to Individual #78's nurse's note, the results of his or her examination of Individual #78 revealed that she had "hard stool high in sigmoid colon (sic)." On the basis of this finding, Individual #78's nurse administered a Dulcolax suppository and was "awaiting [the] results." There was no documentation of Individual #78's's nurse's follow-up assessment of the results/outcome of this procedure. In addition, it should be noted that it was highly unlikely that Individual #78's nurse's digital examination would (or should) have resulted in an examination of Individual #78's sigmoid colon. Re-education and training of Individual #78's nurse in this procedure is recommended. ▪ On 5/25/10 Individual #78's nurses noted that she vomited undigested food and that her lungs were clear, her oxygen saturation was 97%, and there were no signs of respiratory distress or discomfort. On this occasion, Individual #78's nurse also notified her physician who ordered a "speech evaluation re: diet" due to frequent vomiting. Individual #78's physician also instructed her nurse to follow-up with him. There were, however, no nursing assessments or follow-up to Individual #78's change in health status. ▪ On 6/1/10, after eating, Individual #78 again vomited undigested food. On this occasion, her nurse noted that her lungs were clear and her temperature was 97.9. Although Individual #78's nurse noted that he or she would "Continue to monitor," there were no nursing assessments or follow-up to Individual #78's change in health status until 10 days later when she was noted as "constipated." ▪ On 7/18/10, Individual #83's nurse noted that her ankle was swollen, bruised, and she had a slight limp. There was no indication that, on the basis of her nurse's observations, he or she provided basic care and treatment (i.e., cold pack, elevation, immobilization, anti-inflammatory). Individual #83 was seen by her physician on 7/19/10. Her physician diagnosed her with an ankle sprain and ordered her not to bear weight and to take ibuprofen 400 mg three times a day for five days. Over the next 48 hours, although Individual #83's nurse noted that she had a metatarsal fracture, there were no nursing assessments of her ankle and no assessment of her response to treatment. ▪ On 6/17/10, Individual #83's DCS reported to the nurse that she vomited and stated her abdomen was hurting. According to Individual #83's nurse's note, her bowel sounds were present and she received 30ml of Mylanta. There was no nursing assessment of her change in health status or her response to treatment. ▪ For several months Individual #94 has suffered a recurrent dermatitis of his antecubital space, popliteal space, axillary folds, and suprapubic area. Other than the repeated nurses' notes, which were indicative of the frequency with which his rash re-appeared, there were no nursing assessments of his rash or his response to various treatment regimens – triamcinolone versus silvadene versus	

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		pimecrolimus cream. In addition, there were no nursing interventions put forward to address Individual #94's recurrent problems with skin rash/breakdown that clearly failed to improve with applications of various topical ointments/creams. ▪ There was no evidence of nursing assessment and/or follow-up to Individual #97's change in health status and loose stools that occurred on 7/18/10, 7/19/10, and 7/20/10. ▪ On 7/8/10, Individual #54 was seen by his physician in the medical clinic for a dry, non-productive cough and rhinorrhea. There were no nursing assessments of his change in health status or his response to prescribed treatment with Ceron DM three times a day until 7/15/10 when his nurse noted that he had "no cough." At the time of this onsite monitoring review, the Nurse Recruiter reported that the budgeted positions within the nursing department were almost completely filled, and an additional three positions, which were requested in order to create an "overfill" capacity within the nursing department, were awaiting final approval from DADS officials. In addition to staff nurses, EPSSLC used agency nurses to ensure complete coverage of shifts. The Nurse Recruiter reported that the agency nurses had the highest turnover, and that the registered nurse positions were the hardest to fill. She also shared the results of the facility's Job Satisfaction Survey of nurses, which revealed that the two largest areas of dissatisfaction were communication and change (in job duties). Although the facility had undergone significant change in its processes and procedures related to how it conducted its oversight and monitoring of services delivery, and faced almost daily challenges in communicating expectations for performance improvement, as noted in the baseline monitoring review, EPSSLC's nursing staff members appeared to be caring, compassionate, and hard-working nurses who were dedicated to carrying out the facility's philosophy, "…to provide the best care we can for the individuals."	
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.	Nursing assessments existed in each individual's record, however, most of the nursing assessments were not complete or comprehensive and, therefore, a rating of noncompliance has been given to this provision item. The first step of the nursing process that one would expect to find in a facility such as EPSSLC is the nursing assessment. The nursing assessment is an ongoing and continuous process of collecting, evaluating, and communicating data and information regarding each and every individual's needs, regardless of the reason for the nursing encounter. Generally accepted professional standards of care indicate that nursing assessments must be complete, accurate, documented, and accessible to all members of the healthcare team. Moreover, it is from the nurses' assessment that actual problems, high-risk	Noncompliance

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		potential problems, and nursing diagnoses are identified, and from which plans are developed to address and/or resolve problems. All 20 individuals reviewed had annual and quarterly nursing assessments filed in their records. The assessments were conducted by RN case managers, and they were completed in a timely manner. Properly completed, these standardized assessment forms referenced the collection, recording, and analysis of a comprehensive set of health information, that led to the identification of all actual and potential health problems, and to the formulation of nursing diagnoses for the individual. Notwithstanding the presence and use of these forms, in 17 of the 20 records reviewed, nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs. Thus, the conclusion (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs, which were based upon the nursing assessment conclusions/nursing diagnoses, were also incomplete. Examples are given below: <u>Regarding specific individuals</u> ▪ Individual #18's nursing assessments failed to adequately reference his musculoskeletal abnormalities (e.g., congenital hip dislocation, osteoporosis), cardiovascular disease risks (e.g., hyperlipidemia, significant weight gain, lack of exercise), and his oral hygiene problems. ▪ Individual #54's nursing assessments failed to reference his current active medical problems. For example, his endocrine history failed to indicate his hypothyroidism; his genitourinary history failed to indicate his renal stones; his EENT history failed to indicate his episodic conjunctivitis; his musculoskeletal history failed to indicate his osteoporosis; and his gastrointestinal history failed to indicate his episodic anorexia and presence of hiatal hernia. ▪ Individual #157's nursing assessments failed to adequately reference her nutrition and gastrointestinal risks, such as her recurrent episodes of abdominal pain, nausea/vomiting as related to cholelithiasis, and possible cholecystitis. ▪ Individual #1's nursing assessments failed to adequately reference her nutrition risks. The significant correlation between Individual #1's 14-pound weight loss in six months and her inability to eat breakfast or lunch because of her "sleeping all day" was not referenced or captured by her nursing assessment. In addition,	

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		the Sleep History section of her nursing assessments did not reference her psychiatrist's diagnosis of (and regular references to) her "circadian rhythm disorder." ▪ Although Individual #73's nursing summary indicated that her "main nursing problem is loud cries and crying for hours some days," her nursing assessments failed to provide a complete assessment of her psychosocial history and functioning, including, but not limited to, the effectiveness of her medications on her mood and mental status. Regarding numerous individuals ▪ Many of the individuals' skin integrity problems and risks were not adequately assessed by their nurses. Most of these individuals' problems with maintaining intact skin was not due to pressure/immobility per se, but due to one or more of the following problems: self-injurious behaviors, self-inflicted open wounds due to scratching dry and itching skin, recurrent skin infections/rashes (including but not limited to fungal and/or yeast infections), non-healing wounds (including but not limited to ostomy sites), improperly fitting medical equipment, and so forth. ▪ Many of the individuals' sensory deficits, usually vision and hearing impairments, were either not referenced in their nursing assessments or they were significantly under scored. ▪ Ambiguous, imprecise language was used to reference several individuals' health problems and risks, such as "Had a little diarrhea [over the past two months]," "I've heard less yelling this quarter than past time," and "I think she also leaves the cottage less." ▪ The nursing assessments of nine individuals who were prescribed sleeping pills to treat their insomnia/sleep disorders indicated that they had "no problems" sleeping. ▪ The nursing summaries of four individuals indicated that these individuals had severe bouts of crying, screaming, and/or self-injurious behaviors due to "possible pain," but their nursing assessments failed to adequately assess important aspects of their pain (i.e., location, intensity, onset, duration, quality, pain relief, and so forth). ▪ Several individuals who received multiple suppositories and/or enemas a week in order to have a bowel movement had nursing assessments that erroneously indicated that they had "no problems" with constipation.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing	Health management plans and acute care plans existed at EPSSLC. The plans needed a great deal of improvement as detailed below in order to meet the requirements of this provision item. Consequently, this provision was rated as noncompliance.	Noncompliance

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	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.	In a facility such as EPSSLC, the health management plan and acute care plan are designed to promote health and/or prevent, reduce, or resolve the problems and risks that are identified via the nurses' assessment and nursing and medical diagnoses. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals and outcomes. The individuals' status, and the effectiveness of the plans, must be consistently implemented and continuously evaluated and modified as needed. All 20 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Acute Health Care Plans (ACP). These plans were developed by their RN case manager in response to identified health needs, identified risks, and/or significant changes in health status. The forms, processes, and plans in place at the time of the review had many problems and were in dire need of complete review and revision in order to promote progress toward the achievement of this provision item of the Settlement Agreement. Part of the problems noted in the HMPs and ACPs were due to the problems noted above in nursing assessments and diagnoses (sections M1 and M2 of this report). Some general comments are presented below. ▪ Across all 20 individuals reviewed, HMPs and ACPs were in various forms, formats and states of completion. ▪ Across all 20 individuals reviewed, HMPs did not consistently address all of the health care needs of the individuals; and ACPs did not address all of their emergent health care problems and risks. ▪ The interventions in the HMPs were the same across all of the individuals even though the individuals, as well as the precursors, nature, scope, and intensity of their problems, were very different. ▪ Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, their HMPs and ACPs were not revised. ▪ There was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and ACPs to ensure that the plans continued to be appropriate and relevant to the individuals' health status. ▪ The objectives and expected outcomes referenced in the HMPs and ACPs were not individualized, and they did not reflect the individuals' participation in their development or their desired health outcomes. ▪ The Nursing Assessment portion of the individuals' PSPs was not informative and did not provide even a brief recapitulation of the individuals' health status over the past year. In addition, usually only two to three of the individuals' health objectives or goals were mentioned, and, usually, recommendations were	

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		made to "continue" their plans or programs, despite the individuals' progress or lack of progress toward achieving the objectives of their plans or programs. Numerous examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #18 gained over 20 pounds in five months (from March 2010 to July 2010), but he did not have an HMP to address his weight gain. Individual #18 also has significant oral hygiene and skin integrity problems that were also not included in his HMPs. • During Individual #18's PST meeting, although it was recommended that he should have an "oral care program" implemented to meet his oral hygiene needs, he did not have an HMP related to this health issue. Also during his PST meeting, it was noted that he was "on a diet for weight loss." Coincidentally, Individual #18's PST also noted that he received Ensure, chocolate milk, and a "variety of snacks" for his meal refusals. These inconsistent observations were not clarified or explained by his PST, and this significant change in his health and lifestyle was not adequately or appropriately addressed. • Since at least March 2010, Individual #24 has been sleeping during the day and awake at night. Her psychiatrist has indicated that she had a circadian rhythm disorder that was resistant to treatment. This significant change in Individual #24's health and lifestyle had affected her appetite and intake. Thus, she had lost over 11% of her body weight in six months. These issues were not addressed with HMPs and/or ACPs. • Also, there were no addendums to Individual #24's 3/19/10 PSP that referenced her PST's review and discussion of these significant changes in her health and lifestyle. • On 5/4/10, Individual #155 was diagnosed with a urinary tract infection. It was not until 5/11/10 that an ACP was developed to address "pain" associated with her urinary tract infection. • Individual #155's Integrated Progress Notes frequently indicated that she was found with various scratches and bruises of unknown origin on her body. Individual #155 did not have an HMP or ACP to address the risk of injuries of unknown origin or the alteration in her skin integrity. • In addition, although Individual #155's progress notes clearly referenced her gingivitis, missing teeth, dry mucous membranes, coated tongue, bruxism, and tendency to bite her lower lip, her nursing assessment surprisingly concluded that she had "good oral hygiene." As a result, Individual #155 did not have a nursing diagnosis or HMP related to her oral health needs and risks. • On 7/19/10, Individual #59 had two teeth extracted. He did not have an ACP to	

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		address his risks of bleeding, infection, alteration in food/fluid intake, and so forth. • Individual #59 had an HMP (4/22/10) to address his risk of urinary tract infection. On 5/18/10, his nurse noted that he had "possible bleeding from [his] penis." Individual #59's HMP indicated that this sign/symptom of urinary tract infection should be immediately reported to his physician and that various other measures should be taken to appropriately evaluate and treat his possible infection. There was no evidence that Individual #59's HMP was implemented and no evidence that his HMP was reviewed and/or revised in view of this change in his health status. • Individual #59's active medical problems included depression, hemiplegia, ataxia, seizure disorder, osteopenia, hypertension, constipation, dysphagia, GERD, esophagitis, and erosive gastritis. He also had oral hygiene problems (loose, decayed teeth), onychomycosis and tinea pedis, history of UTI, dermatitis, hiatal hernia, and decreased mobility. Individual #59's 11/12/09 PSP did not include a complete list of his health needs and risks, and it was not revised (via a PSP Addendum) to ensure that all of his health needs and risks were appropriately referenced and incorporated into his PSP. In addition, the only information noted in Individual #59's PSP regarding his needs was related to whether or not he needed sex education, a SAM program, and to be restrained for venipuncture/injection, and/or sedation for treatment and examination. The only recommendations noted in Individual #59's PSP were related to improving his tolerance of food and fluid intake, response to seizure medications, and taking his medication for osteoporosis. • Individual #1 had HMPs for alteration in skin integrity, constipation, osteoporosis, and seizures. Although Individual #1's risk of aspiration/choking was graded as "medium," she had no HMP to address this health need and serious risk. • The expected outcomes and goals related to osteoporosis and seizures for Individual #1 were highly questionable. Although Individual #1 was noted as needing "total assistance for transfer" and was "wheelchair only" for mobility, her expected outcome/goal related to osteoporosis was that she would experience "less than <u>two fractures</u>" (emphasis added) during her PSP year. Equally questionable was her expected outcome/goal related to seizures, that is, that she "will have less than <u>31 seizures</u>" (emphasis added) during her PSP year. • From January 2010 to June 2010, Individual #1 lost 19 pounds. She did not have an ACP to address this significant change in health status and lifestyle (i.e., decreased oral intake with increased reliance on bolus enteral feeding). • Individual #2 had HMPs to address her osteopenia, ataxia, impaired skin integrity, GERD, CHF, psychotropic medications, and seizures. Since the	

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		implementation of Individual #2's osteopenia and ataxia HMP, she became increasingly immobile and sustained several fractures. Notwithstanding these significant changes, her HMP was not revised. In addition, Individual #2's HMP related to GERD had not been individualized to reflect the fact that she received nothing by mouth (NPO). • Individual #2 had many significant health needs and risks not addressed by HMPs or ACPs, including oral hygiene problems (e.g., periodontal disease, heavy plaque, missing teeth, foul mouth odor), lethargy and sensory impairments (such that complications related to sensory deprivation were an imminent risk), and recurrent episodes of vomiting and diarrhea. • Individual #104 was a 22-year-old man who was overweight and noted to have several risks related to cardiovascular disease. He had an HMP related to weight management, however, his plan was not individualized and/or appropriate to meet his needs. Rather, it was almost identical to the plan of an obese, 53-year-old woman with heart and lung disease. • Individual #111 had an HMP (2/13/10) to address her potential for altered nutrition and body weight less than her body requirement. Since her HMP was implemented, she lost six additional pounds. Despite Individual #111's lack of progress toward achieving her expected outcome, there were no changes to the interventions in her HMP. • The interventions in Individual #111's ACP (6/2/10) for potential urinary problems related to urinary tract infection were not consistently implemented, and there was no evidence that she was monitored in accordance with her plan. • Individual #69 had HMPs related to seizures, psychotropic medications, and immunizations, and an ACP related to impaired skin integrity. None of Individual #69's HMPs were individualized to reflect the needs, interventions, and desired outcomes specific to an adolescent boy. • Individual #69's ACP related to impaired skin integrity was prepared in response to his receipt of a human bite, which broke his skin. There were no interventions specified in the ACP to ensure that his risk of exposure to a communicable disease had been addressed. • Although during the past year, Individual #69 had an ACP related to skin integrity as well as several incidents of other skin integrity problems (e.g., several nail avulsions with/without infection, cellulitis), Individual #69 did not have an HMP developed to address this health need. • From at least 6/1/10 through 7/20/10, Individual #157 had recurrent episodes of abdominal pain, vomiting, and elevated temperature. On 6/1/10, her physician noted that "…it is very possible that we have early or mild but real cholesystitis. We can work for comfort and if that does not work, go for urgent or emergent surgery…" Individual #157 did not have an HMP or ACP to address	

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		this significant change in her health status. There was also no evidence that her PSP met to review, discuss, and address this significant change in her health, or to develop a plan to ensure that she would not have to experience the risks associated with emergency gall bladder surgery. • According to Individual #73's nursing assessments, "[Her] main nursing problem is loud cries and crying for hours on some days." According to Individual 373's PSP (3/17/10), "[She] will have less crying and need Ativan IM less often." Although Individual #73's nurse and her PST agreed that she should have less crying, there were no plans (via PSP, HMP, ACP, etc.) to address her "main" nursing problem. From beginning to end, Individual #73's psychosocial history was full of reasons why she may cry. Nonetheless, despite her assessed capacity to verbalize her wants, needs, likes, and dislikes, no plans were developed or implemented to meet her significant psychosocial needs, other than prescribing and administering psychotropic medications. • Individual #115 had an HMP (4/8/10) to address his constipation. Despite his many problems with constipation during May 2010, including, but not limited to, hard stools, fecal impaction, straining, and crying during bowel movements, his HMP was not reviewed or revised. • Individual #94 had an HMP in place for skin integrity for over six months. Despite his recurrent skin breakdown in his antecubital and popliteal spaces, axillary folds, and suprapubic area, his HMP had not been revised with alternate, individualized treatment interventions and strategies, nor had it been revised to reflect the fact that his skin integrity problems were not limited to the areas affected by his bowel and bladder incontinence. • Individual #52 was one of only four residents at the facility who was identified as Do Not Resuscitate (DNR). Individual #52 did not have an HMP addressing the medical, nursing, and health care related components of her end of life plan, wishes, and so forth. This was a significant oversight that should be addressed.	
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.	At EPSSLC, nursing assessment and reporting protocols were in place, however, the presence of protocols was not sufficient to ensure that the health status of the individuals at EPSSLC was consistently addressed. The facility's implementation of its nursing assessment and reporting protocols was in the early stage of implementation. As noted, there were numerous problems, described above in sections M1, M2, and M3. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not evident in the records reviewed. Therefore, this item was rated as being in noncompliance. At EPSSLC, the Chief Nurse Executive, Nursing Operations Officer, Nurse Educator/Hospital Liaison, Nurse Recruiter, Infection Control Nurse, Quality Assurance	Noncompliance

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		Nurse, Campus Nurse Supervisors, Nurse Case Managers, and Nurse Managers all had a role and responsibility to ensure the implementation of nursing assessment and reporting to address the health status of the individuals. The expectation for adequate numbers of trained, competent, and capable nurses was clearly articulated by the Chief Nurse Executive and the Nursing Operations Officer. During interviews with the Chief Nurse Executive and the Nursing Operations Officer, it was reported that nursing policies and procedures are in place to govern the conduct of nursing assessment and reporting. They stated that since the baseline monitoring review, there were more nurses working at EPSSLC, better retention of these nurses, and a constant focus on ensuring that the nurses were competent to conduct their job duties, in accordance with policies, procedures, and expectations of monitoring/QA reviews. They also reported that in the past, the facility's numerous disciplines were more segregated and isolated from one another. Now, they were striving to work as a team. For example, it was once the case that only nurses met to review the health status of individuals, whereas now, nurses, dieticians, therapists, pharmacists, managers, and others met together to review the health care needs of the individuals. Notwithstanding these efforts and improvements, one of the barriers that persisted was the lack of authority of the Dorm or Cottage nurse to direct or manage the delivery of health care services and duties delegated to direct care staff members. The Nurse Recruiter echoed the CNE and NOO report of steady improvement in the recruitment and retention of nurses. She reported that she received a lot of support from the facility's director regarding the improvement of salary differentials and wages. She also revealed the results of the Job Satisfaction Survey, which indicated that nurses would like better communication within the Nursing Department, especially when changes occurred. In order for the Nurse Recruiter to improve the facility's recruitment and retention of nurses, she indicated that she needed direct access to the electronic/on-line submission of nurses' resumes (e.g., Career Builders, facility's website). This is an area that the facility may want to review and consider with input from its administrative personnel. The Infection Control Nurse was directly involved in the daily process of nursing assessment and reporting. He attended the DCS shift reports and the nurses shift reports to receive information about any new infections and the status of identified infections and infection control at the facility. The Infection Control Nurse also received information from the facility's Medical Director and Pharmacist related to antibiotic prescriptions and practices across the facility. All of the information related to identification, tracking and trending, and reporting of infections was recorded by the Infection Control Nurse who reported these data to the facility's Infection Control Committee.	

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		The Infection Control Nurse made it his business to provide DCS with re-education and training in standard precautions and to follow-up on individuals who were diagnosed with infections. The Infection Control Nurse also provided technical assistance to Dorm and Cottage nurses who had questions about specific infection control practices and procedures. In order for the Infection Control Nurse to be more effective in reducing the incidence of infections at EPSSLC, however, he needed authority to impose infection control processes and procedures and institute mandatory re-education and training of individuals and staff members at the level of the Dorm/Cottage where better infection control was needed. The Hospital Liaison/Nurse Educator was directly involved in the daily process of nursing assessment and reports. She loved her job and was passionate about ensuring that all individuals who were hospitalized were visited, and that all pertinent information about their hospitalization was collected and reported to their caregivers at EPSSLC. She communicated her assessment of individuals' hospital care/treatment and their response to treatment via verbal reports at morning (nursing) staff meetings and written reports, which were sent to the individuals' nurse case managers, physician, and DCS Supervisor, and were also filed in the individuals' records. The Hospital Liaison/Nurse Educator also ensured that annual competencies and new employee orientation was scheduled and conducted as needed. She kept lists of employees/nurses who needed their annual competencies and/or monitoring of medication administration, and she informed the Charge Nurses of who was in need of training. In order for the Hospital Liaison/Nurse Educator to improve upon her ability to obtain timely, relevant information from various clinical professionals at various local hospitals about individuals who were hospitalized, she needed flexibility in her scheduling of hospital visits. For example, at some hospitals, the Hospital Liaison/Nurse Educator must schedule her visits during early morning hours in order to ensure that she is able to meet with appropriate hospital staff members, collect information, and return to the facility with important information to report at the morning staff meeting. Interestingly, at EPSSLC, the Quality Assurance Nurse was not a member of the Nursing Department. She was a member of the Quality Enhancement Department and reported to the Director of Quality Enhancement. Nonetheless, is the QA nurse was involved in all aspects of quality oversight of the delivery of health care services to individuals at EPSSLC. Further, she was a member of many of the facility's committees (e.g., Medication Error, Infection Control, HST, Skin Integrity). In the meetings attended by the monitoring team, her input was based upon her knowledge of the individuals and facility operations,	

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		and her experience with taking large amounts of data and information and making it useful and relevant to the processes and individuals affected by the processes. During the month preceding the review, at the request of State officials, the QA nurse's internal quality assurance monitoring system and tools underwent complete and total revision. Since June 2010, she was assigned six areas to review and monitor. These areas were Health/Nursing Care Plans, annual assessments, medication administration and documentation, documentation, seizure management, and acute illness/injury (ACPs). At the time of the review, she was also immersed in a study of "inter-rater reliability" among reviewers at the facility. The results of this study were undetermined. (Also see section E of this report.) It remained unclear how the role as the facility's QA Nurse was being effectively utilized by the Nursing Department. This question was especially relevant given her new monitoring assignments and tools, ones that focused heavily on the Nursing Department. Finally, the picture of nursing assessment and reporting protocols and processes at EPSSLC would not be complete without the role and responsibilities of the RN Case Managers, Campus Nurse Supervisors, and Nurse Managers. These were the nurses who were responsible for data gathering and direct observations of individuals, documentation, collection, aggregation, and interpretation of these observations/data, and communication of these observations and data through assessments (verbal and written) to members of the individuals' personal support team (PST). If there are problems at this level of actual nursing assessment and reporting, there will be problems at each and every level as are referenced above in sections M1, M2, and M3 of this report.	
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.	EPSSLC had a health risk assessment rating tool and held a regular health status team meeting. As noted in the baseline monitoring report, and as has continued, these processes were fraught with problems that resulted in what appeared to be incorrect ratings of risk for most individuals in most areas of risk. Therefore, this provision item was rated as noncompliance. EPSSLC implemented a Health Risk Assessment Rating Tool to assess and identify each individual's levels of risk (low, medium, or high) across a number of particular areas: seizures, aspiration, choking, medical, cardiac, constipation, dehydration, diabetes, GI concerns, hypothermia, osteoporosis, polypharmacy, respiratory, skin integrity, UTIs, weight, injuries, and their overall risk level. These rating tools were completed in conjunction with individuals' PST meeting and annual PSPs, but they were not consistently reviewed/revised when there were significant changes in individuals' health status and needs.	Noncompliance

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		During the onsite monitoring review, the monitoring team attended the facility's Health Status Team (HST) meeting. The HST was chaired by the facility's Medical Director and was very well attended by every discipline. Forty individuals were reviewed during this meeting. During the review of an individual, representatives of each discipline provided their assessment of the individual's risk as it pertained to their domain or area of specialty. For example, the physical/occupational therapist representative provided his or her assessment of the individual as it was measured by the Braden Scale, fall risk, and so forth. The dietary representative provided his or her assessment of the individual as measured by the BMI and IBWR. Although a few disciplines provided assessments of the individual based upon specific, measurable criteria, many did not. Many provided assessments based upon very subjective criteria that were not stated in clear, measurable terms. Some examples are provided below. • When assessing an individual's constipation risk, the clinical professional indicated that an individual was low risk because he/she "takes docusate sodium" and "doesn't need suppositories." • When assessing an individual's behavior risk, a clinical professional indicated that an individual was low risk for challenging behavior on the basis of their assessment, which was, "He does have behaviors, but he's alright." • When assessing an individual's fracture risks, the pharmacy representative indicated that an individual was at medium risk for fractures because he had osteopenia and received medication for the same. But, another clinical professional indicated that she thought that the individual was low risk for fractures because she "had no fractures." Thus, the group consensus and the individual's overall fracture risk was determined, "[She] sounds like a low." The entire portion of the meeting that was attended by the monitoring team was conducted in this manner. Thus, it was not surprising that most of the individuals reviewed were determined to be at either low or medium risk. Thirteen of the 20 individuals whose records were reviewed were also reviewed by the HST. All of the 20 individuals reviewed had multiple risks related to their health and/or behavior. The apparent correlations between and among risks, however, was not adequately identified and/or addressed by the HST. For example, a review of Individual #59's record revealed a possible correlation between his high risk of seizure activity and his risk of falls and injuries of unknown origin. The nature and impact of Individual #59's risk of seizures on his risks of falls and/or injuries, however, was not adequately	

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		identified or reviewed by the HST. Individual #97 was designated at high medical risk. He had many health problems and needs that clearly justified this rating, however, the relationships between his medical risks and their impact on his health and well-being were not adequately identified and addressed by his HST. One example: For many months, Individual #97 had a problem of altered skin integrity at his g-tube site, and, at the time of the review, his wound was positive for MRSA infection. Notwithstanding these problems, he wore an abdominal binder, which extended almost the full length of his trunk, in an effort to reduce the likelihood that he would contaminate his wound, spread infection, or dislodge his gastrostomy tube. The HST, however, did not identify and/or discuss the impact of the use of an abdominal binder on his continual problems with skin integrity, the risk of spreading infection if the binder was not properly removed/disinfected, and/or his pain/discomfort related to wearing the binder, the severity of which was not assessed by his nurses because Individual #97 was "unable to describe his pain." It should also be noted that Individual #97's HST did not discuss whether or not a consultation with a wound care and/or infectious disease specialist was needed given the long history of problems. According to the HST, Individual #111's risk was overall "low." Individual #111's record indicated that she was at high risk for osteoporosis due to her osteopenia. Nonetheless, the HST concluded that since Individual #111 has not suffered a fracture, she was "low risk" for fractures. The HST did not incorporate a review and analysis of Individual 111's risk of fracture/injury, or her vision impediments, which included partial optic atrophy and bilateral cataracts. The HST also did not adequately identify and address Individual #111's anorexia and potential for alteration in nutrition and undesirable weight loss. This was especially relevant since Individual 111's record revealed that, from January 2010 to July 2010, she lost nine pounds. Individual 111's 1/20/10 PSP Addendum indicated that in August 2009, she had a goal/plan designed for weight loss, but this goal/plan was revised to reflect the fact that additional weight loss was not a desired outcome. Please also see section I of this report.	
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	The administration of medication and the management of the medication administration system at EPSSLC had improved since the baseline monitoring tour. As indicated in more detail below, additional work still needed to be in the areas of proper completion of the MARs, management of the medications by the nurses, and in the oversight of medication errors. Therefore, this provision item was rated as noncompliance.	Noncompliance

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	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.	Observations of medication administration were conducted on Dorms A and C and Cottages 506, 509, and 512. During all observations, nurses properly washed and disinfected their hands prior to medication administration and between individuals; they identified the individuals receiving medications; they adhered to the accepted standards of medication administration; they did not initial medications prior to the individuals' receipt of the medications; and they ensured individuals' privacy and dignity. All of the 20 individuals reviewed had a "SAM" (self-administration of medication) assessment and designation filed in their record. The 20 individuals reviewed were designated as either not able to participate or in need of "verbal prompt" to participate in the self-administration of medication. During the observations of medication administration all individuals were treated with respect, however, there were little to no distinctions made between the individuals who had abilities to participate more versus the individuals who had abilities to participate less in the self-administration of medications. Only one of the observations of medication administration (Cottage 509) revealed interactions between the nurse and the individuals where steps had been taken to involve the individuals in self-administration of their medications beyond the verbal prompt, "Take your medicine." The nurse who administered medications on Cottage 509 spoke to the individuals about the medications that were prescribed prior to administration. For the individuals (Dorms A and C) who received enteral administration of medications, their nurses checked their stoma sites and abdomens for signs of distension, pain, and so forth, checked the positions of the individuals and their feeding tubes, appropriately flushed and clamped their feeding tubes, and properly administered the individuals' medications in accordance with their physician's orders. According to the Nurse Educator, since February 2010, 100% of the nurses were monitored every three months on their medication administration practice. The results of the medication monitoring reviews were filed in the nurses' personnel files. According to the Nurse Educator, not one of the monitoring reviews has resulted in a "bad score" and/or a recommendation for a nurse to receive re-education/training in medication administration. As noted in EPSSLC's baseline monitoring review, and as observed during this onsite monitoring review, the facility continued to implement a system of medication administration and reconciliation that led to medication errors and placed an overwhelming demand on the time and attention of staff members, including, but not limited to, nurses, pharmacists, managers, and administrators. For any one individual at any one point in time, there were anywhere from one to several MARs (Medication	

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		Administration Records) with various time frames that referenced both current and discontinued medications, with many typed, crossed-out, handwritten, entries. The MARs were confusing, difficult to decipher, and impossible to reconcile with the medications on hand, that is, the medications in the bins. The review of 20 individuals' MARs for May 2010 and June to July 2010 revealed problems of omissions and/or discrepancies in the MARs of 15 of the 20 individuals reviewed. These omissions and discrepancies included many missing entries for anti-seizure medications, anti-hypertension medications, bowel medications, antibiotics, PPIs, psychotropic medications, sleeping pills, vitamins and supplements, enteral feedings, vital signs, blood-sugar levels, topical ointments/creams, and other medications. There were many missing entries noted in May 2010 and a similar pattern of missing entries was noted for June to July 2010. Several examples of the missing entries for June-July 2010 are shown below: ▪ Individual #111: MAR did not indicate that she received her carbamazepine on 6/1/10. ▪ Individual #69: MAR did not indicate that he received his lamotrigine on 6/1/10 and 6/5/10, Seroquel on 6/5/10, Calcarb on 6/5/10, Banzel on 6/5/10, and ammonium lactate cream to his hands on 6/5/10. ▪ Individual #73: MAR did not indicate that she received her topical foot treatment on 7/5/10 to 7/8/10; no vital signs recorded as ordered on 6/30/10, 7/3/10, and 7/16/10; and no results of Dulcolax suppository was recorded on 7/12/10. ▪ Individual #157: MAR did not indicate that she received her 7/6/10 simvastatin. ▪ Individual #2: MAR did not indicate that she received her cholestyramine/sucro packet on 7/3/10 and 7/9/10; and it did not indicate that she received her 250 ml water flushes every shift on 6/22/10 to 7/18/10. ▪ Individual #118: MAR did not indicate that she received her Glucerna 1.5 1 ½ cans qid on 6/22/10, 6/23/10, and 7/19/10. ▪ Individual #115: MAR did not indicate that he received his calcium with vitamin D on 6/24/10, docusate sodium on 6/24/10, lactulose on 6/22/10 and 6/24/10, lamotrigine on 6/22/10 and 6/24/10, rufinamide on 6/24/10, zolpidem on 6/24/10, zonisamide on 6/24/10, Promote with fiber 2 cans four times a day on 6/24/10, and no results of stat doses of Valium and loperamide. ▪ Individual #155: MAR did not indicate that she received her Jevity 2 cans with 200 ml bolus water three times a day on 6/25/10 and 7/6/10 and her chlorhexidine mouthwash on 7/8/10. ▪ Individual #97: MAR did not indicate that he received his levetiracetam 6/20/10 and 7/9/10, Fosamax 6/22/10, 6/29/10, and 7/5/10, Cipro 6/20/10 to	

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		6/21/10, docusate sodium 6/20/10 to 7/9/10, Prevacid 6/20/10 to 7/9/10, Lexapro 6/19/10 to7/9/10, simvastatin 6/19/10 to 7/9/10, multivitamin mineral liquid 6/20/10 to 7/9/10, and Bactrim twice a day on 6/19/10, 6/20/10, and 6/21/10. ▪ Individual #106: MAR did not indicate that he received his accu-checks on 7/3/10, 7/11/10 to 7/12/10, and 7/17/10, docusate sodium 7/19/10 to 7/20/10, doxepin hcl 7/19/10, lactulose 7/19/10 and metoprolol on 7/19/10. ▪ Individual #18: MAR did not indicate that he received his Thorazine on 6/2/10 or 6/12/10. At the time of the review, there were several initiatives underway to address the facility's problems with ensuring a system of safe, accurate, and accountable medication administration that comports with the generally accepted professional standard of care and that met the facility's goal to deliver the best care possible. One of the initiatives to address medication errors was the establishment of a Medication Error Committee that was comprised of nursing leadership, nurse case managers, ancillary nurses (e.g., Quality Assurance and Infection Control Nurses), pharmacy leadership, and program representatives. This committee met monthly; reviewed medication error trend reports, bin tracking reports, action plans/POI, and pharmacy reports; and made recommendations for improvement based upon the results of their reviews. The two nurse case managers, who had done a lot of the investigation on the medication error reduction project, continued to devote a substantial amount of time and energy to making the project a success. They had good ideas and made excellent suggestions about how to help nurses "think and be more accountable" and help "raise standards and expectations" for proactive attention to be paid to safe medication administration. On 7/20/10, the monitoring team attended the Medication Error Committee. During this meeting, the Director of the Pharmacy reported that she had started to note that there were not as many medications returned to the pharmacy without explanation or justification. The Chief Nurse Executive reported the results of Medication Error monthly reports and noted that the reports indicated a decline in errors and an overall medication error rate of 0.0168% (which is a rate of less than two errors per 10,000 medications administered). By any standard, this rate would be indicative of a highly successful system of medication administration and accountability, however, this was not the current state of affairs at EPSSLC. It was a widely known and recognized fact that medication errors had been and	

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		were a real problem at EPSSLC. The root cause of the problem had been difficult to identify and the interventions to address the problem were still in their early stages of development and implementation. So, how is it that the medication error rate that was calculated and presented through the Medication Error Committee was so small? The answer is that the denominator of the rate was the total number of medications administered at the facility (approximately 90,000 medications were administered per month) and the numerator was the reported number of errors. This did not include the potential number of errors, that is, the number of medications that were returned to the pharmacy without explanation or justification, and/or the blank entries in the individuals' Medication Administration Records that suggested (or perhaps clearly indicated) "missed" medications (i.e., medications that were never administered to or received by the individuals). In order to address the problem of potential missed medications, one of the strategies that had been implemented were shift-to-shift counts of medications. Before a medication nurse went off duty, he or she was required to count and record each medication for each individual on a pink sheet (a pink-colored medication reconciliation form). According to informal interviews with nurses, the shift-to-shift counts coupled with the counts related to "bin exchanges" was excessive and overly time-consuming. Thus, it was not surprising that a review of the pink sheets on Dorms A, B, and C and Cottages 506, 508, 509, 511, 512, and 513 revealed that none of the pink sheets were complete. More specifically, every sheet on every Dorm and Cottage had blank entries where medication counts should have been recorded. It did not appear that facility senior management was aware of this problem at the time of the onsite monitoring tour.	

Recommendations:

1. Ensure that nurses consistently document health care problems and changes in health status, adequately intervene, and appropriately record follow-up to problems once identified.

2. Articulate expectations for what information must be communicated during shift to shift reports.

3. Use a structured form/format for this shift to shift exchange to help ensure more complete presentation, clearer communication, and better participation in the process.

4. Ensure that nursing assessments are complete and comprehensive.

5. Integrate the various problem-centered health management plans (HMPs) into one person-centered HMP that is regularly reviewed, revised, and updated as individuals experience significant positive and/or negative changes in their health status.

6. Incorporate the reviews of ACPs as part of the facility's overall plan/process to ensure that individuals' health risks are adequately identified and addressed.

7. Adopt a health risk screening tool and assessment process that includes the review and analysis of specific, objective, measurable data to codify/measure health risk.

8. Clarify who is responsible for conducting and ensuring the ongoing training of direct care professionals in individuals' health needs, HMPs, and ACPs.

9. Ensure that the staff who have been delegated health care duties are capable and competent to perform those duties.

10. Streamline "monitoring" and oversight activities to better utilize nursing supervisors' and RN case managers' time in areas of mentoring, training, and assisting direct care staff members with delivery of health interventions to achieve positive outcomes for individuals.

11. Assign the Pharmacy and Therapeutics Committee the task of researching and proposing to the facility administrator several options for a more current medication administration system that supports medication administration practices, which are safe, accountable, and cost-effective.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix: Pharmacy and Therapeutics Guidelines o Quarterly Drug Regimen Reviews o Drug Utilization Reports o MOSES and Discus Scales o Pharmacy and Therapeutic Committee Meeting Minutes, 12/09, 3/10, 4/10, 5/10, 6/10 o EPSSLC Medication Errors, 9/09 – 6/10 o Lab procedure Matrix , dated 7/25/2007 o Pharmacy Policy and Procedure Manual, dated 5/20/10 (Inventory Control and Clinical Functions were not included in the manual and were not available) o EPSSLC Adverse Drug Reactions, dated 11/2009 o Pharmacy Notification of Severe Drug Interaction Order o Records for the individuals listed in Section L Interviews and Meetings Held: o Ken Wiant, MD, Medical Director o Salvador Molina, M.D., Staff Physician o Amista Salcido, Pharm.D., Pharmacy Director o Sandra DeLong, R.N., Chief Nursing Executive Observations Conducted: o Tour of pharmacy with pharmacy director o Medication Error Committee Meeting o Pharmacy and Therapeutics Committee Meeting
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Overall, there were no grossly unsafe practices noted during this review. The hiring of a new pharmacy director, and the initiation of new procedures indicated that further improvements were likely, however, due to the recency of these changes, not all new practices were in place and therefore this provision was found to be in noncompliance.

	The extent of medication errors in the facility, however, was unknown. The pharmacy had not been reporting errors to the Medication Error Review Committee (MERC)and physician errors appeared to go unreported. While personal accountability of every employee is important, it is likely that many of the errors being produced were being set-up by a medication dispensing system that was outdated and prone to errors. A new director of pharmacy services was hired recently. She appeared to be experienced and to have several good recommendations for improving pharmacy services at the facility. Several new systems had been introduced over the past six months. It was evident that these systems were not fully implemented and, at this point, offered minimal useful information. One system that had not been implemented, but should be developed quickly, was the team responsible for monitoring the use of stat and prn drugs. Although, staff reported no use of prn medications, records provided information indicating the repetitive use of psychotropic agents for behavioral control. This practice must be examined and corrected.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's 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.	There was no evidence of a formal process for conducting a prospective review of an individual's medication regimen and, therefore, this provision item was rated as being in noncompliance. The Pharmacy Policy and Procedure Manual did not contain any procedure that met this requirement. The manual, approved on 5/20/10, contained many policies and procedures with revision dates of 2001 and 2005. There was evidence that reviews of medication regimens sometimes occurred prospectively and retrospectively. There was no process to verify that a prospective review occurred with each individual's medication. The following are examples of medication regimen reviews conducted at EPSSLC: • A Drug Regimen Review (DRR) was found in all of the records reviewed. They will be discussed in detail below in other provisions of this section N. • The pharmacy director reported that the facility utilized WORx pharmacy software that provided checks for therapeutic duplication, drug interactions, allergies, and other issues upon entering a new medication. In the case of a severe drug interaction, the form "Pharmacy Notification of Severe Drug Interaction Order" was completed and faxed to the physician. According to the form, the following direction was given to the facility: "In compliance with DOJ agreement mandates, all medication orders with severe interactions must be held and the physician notified. The physician must sign that he/she is aware of the risk associated with the order and return this for the pharmacy acknowledging such as and any change in order status." Two examples are provided below. • Individual #106:	Noncompliance

#	Provision	Assessment of Status	Compliance
		◦ Order written by the physician on 7/12/10 at 1:33pm. ◦ The pharmacy notification was completed on 7/12/10 and sent to physician who made changes to the drug regimen. • Individual #74: ◦ Order written by physician on 3/8/10 ◦ The pharmacy notification was completed on 3/8/10 and forwarded to the physician with the drug monographs and recommendation for drug changes. The physician accepted the recommendation and made drug changes. The pharmacy director reported that the pharmacist contacted the physician for other problems noted upon order entry when clarification was needed. Clarification of drug orders were noted on the physician order form. The pharmacy director was beginning to maintain some data on this process.	
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.	Drug Regimen Reviews were completed on all of the records reviewed. In most cases, these were completed quarterly. Second quarter reviews were present in only a few of the charts reviewed. The pharmacy director reported that these were in the process of being completed. More work is needed in this area and, therefore, this provision item was rated as being in noncompliance. The Drug Regimen Reviews included a summary of findings and provided recommendations to the PCP. The summary of findings included information on: • Presence of polypharmacy • Delivery device, dose, frequency, and route of administration • Potential drug interactions • Monitoring and evaluation of drug effectiveness, side effects, toxicity and adverse effects • Appropriateness of pharmacotherapy and consistency with psychotropic prescribing guidelines Recommendations were provided to the physician for review. Comments from pharmacists included recommendations for lab monitoring, checking bone mineral densities, and monitoring for medication side effects. In most instances, the physician concurred with the findings of the pharmacists and signed off on the document. In general, there were some issues noted with medication regimens that were not presented in the DRRs: • Acetaminophen was prescribed to every individual covered by the record reviews. The indication for the order was pain and temperature. The actual	Noncompliance

#	Provision	Assessment of Status	Compliance
		order gave no guidelines for physician notification. • Ibuprofen was prescribed to individuals with a diagnosis of erosive gastritis or gastritis. • Individuals with behavioral issues received pseudoephedrine. • Ativan was prescribed for "unmanageable behavior."	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	There was no process in place to meet this provision. The quarterly drug regimen reviews provided some information on polypharmacy, benzodiazepine use, and anticholinergic load. That process did not reflect any collaboration between practitioners and pharmacists, nor did it provide adequate clinical justification for the use of benzodiazepines and polypharmacy. Pharmacy and Therapeutics Committee meeting minutes addressed the need for attention to the issues of polypharmacy and psychoactive drug use, anticholinergic burden, and benzodiazepine use. Minutes from the 5/20/10 meeting documented that "A formalized review process which includes the Medical Director, and Psychiatrists will be developed by the Clinical Pharmacist."	Noncompliance
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.	The records contained some evidence that the pharmacists were making recommendations to the medical practitioners. Recommendations were noted on the severe interaction form as well as the Drug Regimen Reviews. This system was also in development at the time of the onsite monitoring tour. The severe interaction form was completed at the time of order entry and the physician was required to respond in order for the medication order to be processed. There was evidence that the physicians considered the recommendations and made appropriate changes. The Drug Regimen Reviews contain a checkbox for the medical practitioners to agree or disagree with recommendations. In most cases, the practitioner checked the "agree" box.	Noncompliance
N5	Within six months of the Effective	The MOSES and DISCUS rating scales were completed in the records reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	In several instances, the tools provided valuable information to the medical practitioner. There was little evidence, however, that the medical practitioners took these findings into consideration in making treatment decisions. Below are several examples of side effects documented, and the practitioner's consideration of the side effects. In all of the examples, the side effects had the potential to have a significant impact on the individual's quality of life. The MD did not engage in any feedback or discussion related to the side effects. • Individual #78 o 12/9/09 MOSES ▪ Decreased appetite ▪ Swallowing difficulty -- MD response: Benefits outweigh side effects o 6/17/10 MOSES ▪ Requires bisacodyl suppositories every 3-4 days -- MD response: Benefits outweigh the risk • Individual #47 o 12/18/09 MOSES ▪ Swallowing difficulty -- MD response: Benefits outweigh the risk o 6/17/10 MOSES ▪ Tics, restless and incontinence -- MD response: Benefits outweigh the risk	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility had a procedure in place for reporting adverse drug reactions. The procedure was implemented in November 2009 and since that time, three adverse drug reactions had been reported. The data collection tool used did not contain a probability scale, a severity scale, or individual outcome thresholds. The facility's procedure did not indicate when an intense case analysis would be required. Three adverse drug reactions were reported during the past six months. Individual#99: 12/17/09: Acyclovir was suspected of causing urticaria. The reporting form was incomplete. The current medication list and actions were both blank. There was no description of a temporal relationship between starting the drug and the onset of symptoms. The Pharmacy and Therapeutics Committee meeting minutes contained no discussion of the ADR.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual#95: 12/23/09: Fergon was suspected of causing black tarry stools. The form was completed. The Pharmacy and Therapeutics Committee meeting minutes contained no discussion of the ADR. Individual#74: 6/21/10: Lovenox was suspected to cause a rash to the forearms. Recommendations and actions were not completed by the MD. The ADR was reviewed in the July Pharmacy and Therapeutics Committee meeting. Record reviews demonstrated several adverse drug reactions that could have been reported such as: • Hyponatremia associated with trileptal • Hyponatremia associated with carbamazepine • Hyperprolactinemia and hyperglycemia associated with atypical psychotropics	
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.	Four Drug Utilization Evaluations (DUE) were reviewed dating from October 2009 to May 2010. The requirements for this provision had not been codified into policy and procedure. The DUE operational procedure was listed as pending. The Pharmacy and Therapeutics Committee Meeting minutes documented discussion of the DUEs. The minutes of the 3/31/10 meeting contained the approved calendar that required one DUE to be performed each month. The rational, such as high risk or high use drugs, for drug selection was not included within the context of the minutes. There were no reports documented for DUEs during the months of June and July. The minutes documented presentation of DUEs on the following drugs: • 10/23/09 – Risperidone • 12/22/09 – Naltrexone • 3/31/10 – Benzodiazepine Use • 5/20/10 – Chlorpromazine The DUEs completed provided data on the number of persons prescribed the medication as well as dose ranges. The DUE on benzodiazepines and falls generated a series of corrective actions, such as educating nursing staff on akathesia and reviewing data and findings with the medical staff. Subsequent meetings did not document completion of these corrective actions.	Noncompliance
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular	The facility had a policy on medication variances/errors in place. The Medication Error Review Committee (MERC) received data on variances and, following analysis and discussion, presented those finding to The Pharmacy and Therapeutics Committee. P&T minutes documented that the MERC was inactive for several months. Recently, the two	Noncompliance

#	Provision	Assessment of Status	Compliance
	documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	committees responsible for medication variances had began to meet more regularly to discuss how to improve in this important area. Improvements were noted in the areas that reported data but the system was incomplete: • During interviews with the chief nurse executive, medical director, and the pharmacy director, all three acknowledged that the only medication errors being reported were those that involved nursing. • The pharmacy director indicated that she tracked pharmacy errors internally and took appropriate corrective actions. The pharmacy policy on dispensing errors required that pharmacy track and trend all dispensing errors that left the pharmacy and report those to the MERC. MERC minutes, dated 5/28/10, documented the request from the chief nurse executive to have all physician and pharmacy errors forwarded to her. • The medical director acknowledged a lack of reporting of physician medication variances. (see table below) • A substantial amount of bin errors occurred. Bin errors were meds retuned to the pharmacy in bins. If no explanation was obtained for these meds, they were treated as omission errors. o A corrective action plan was implemented that resulted in a substantial decrease in bin errors. The plan was effective, but utilized a significant amount of nursing resources to complete reconciliation. • The P&T minutes contained corrective actions for the bin errors, but no corrective actions were documented for the other errors. • The MERC minutes of 5/28/10 documented a medication error that occurred for three consecutive months. This was an omission error related to an individual going to school. The minutes do not contain any discussion of further analysis of the error or any corrective actions. A drug omission of three months duration warranted further discussion and case analysis.	

	Jan	Feb	Mar	Apr	May
Medication Errors	7	6	8	13	12
BIN Errors	267	269	53	43	55

Recommendations:

1. The facility needs to implement the systems of oversight for drug review, polypharmacy review, and psychotropic use. Several of these issues

will need input from disciplines other than health care professionals. An oversight committee that looks at the use of psychotropics should benefit from input from psychology services.

2. The adverse drug reporting was not fully implemented. The ADR system was missing some key components. A tool is needed that is user friendly, provides prompts to the user, and uses objective methodology to determine if an adverse event has occurred. There are several rating scales that are commonly used to achieve this. It is also imperative that staff be educated on this topic if reporting is to increase.

3. The Drug Use Evaluations had not been fully implemented and should be. This system can provide valuable information to the facility because it monitors the use of various drugs.

4. Physicians should review the Drug Regimen Reviews and side effect rating scales more thoughtfully when abnormalities and side effects are reported.

5. The facility must give serious consideration to changing the current medication system. A tremendous amount of resources were being utilized with weekly medication deliveries and drug reconciliations. The facility should investigate the options that are available for dispensing pharmaceuticals. Some of these are available at little to no additional costs for the facility and have been modeled in SSLCs in other regions.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o Current Census by Home o Physical Nutritional Management policy #012, 12/17/09 o Nutritional Management policy #013, 12/17/09 o At Risk Individuals policy #006, 10/5/09 o EPSSLC Plan of Improvement for PNM o POI Supplement for PNM o PNMP Committee List o Credentials for OTs, PTs, SLPs, RDs o Sign-in sheets for Webinars (8/4/09 to 12/30/09) o HST Risk List of Individuals at Risk for Osteoporosis, Seizures, Dehydration, Aspiration, Respiratory, Weight, Constipation, Skin Breakdown o PNMPs for individuals submitted o Gastrostomy Tube Orders as of 6/1/10 o AAC/Communication Assessment Report template o Fall Incidents 6/1/09 to 6/23/10 o List of Individuals seen in ER o Individuals with skin breakdown 9/09 to 6/10 o BMI readings for sample o List of individuals with pneumonia diagnosis o Wheelchair Master list 2009 to 2010 o Mat Assessment for Seating and Positioning template o NEO training materials o List of individuals with PNM needs o Individuals on Modified and Changed Diets o NMC Screening Tool template o RTT3 Facilitator for PT 2010 o Trial PNMP Risk Monitoring o Monthly OT/PT Report October 2009 to May 2010 o List of individuals with poor oral hygiene status o Guide for PNMP Monitoring and associated training materials meeting o List of individuals who required assistance at meals o Skin Integrity meeting agenda and data 7/21/10 o HST Meeting Agendas for 7/21/09 to 6/16/10 o Wheelchair Clinic Work Order spreadsheet o Lifting Transfer Monitoring forms 5/10

	- List of PT/OT Screenings and Referrals - Mealtime Observation forms June 2010 - PNMP Monitoring forms June 2010 - PNMP training sign in sheets 1/10 to 6/10 - Individuals on Thickener list - List of Hospital Admissions since 1/1/ 10 - New Admissions 6/1/09 to 7/20/10 - PNMP Committee documentation 1/1/10 to 7/14/10 - NMC Reviews spreadsheet - NMC Annual spreadsheet - List of individuals with skin breakdown - Slip/Trip/Fall data base - List of Injuries - List of Falls - Individuals with BMI over 30 - Individuals with BMI less than 20 - PNMP Committee Meeting supporting documentation (5/12/10 and 6/9/10) including NMC Screening Tools, PNMP Drafts, Nutritional Management Committee Reports - Modified Barium Swallow Study reports for the following: - Individual #40, Individual #9, Individual #22, Individual #18, Individual #13, Individual #123, Individual #45, Individual #68, Individual #4, Individual #54, Individual #152, Individual #21, Individual #23, Individual #115, Individual #34, Individual #78, Individual #83, Individual #84, Individual #118, Individual #15 - OT/PT Assessments for the following: - Individual #19, Individual #16, Individual #114, Individual #72, Individual #87, Individual #183, Individual #102, Individual #105, Individual #111, Individual #75, Individual #7, Individual #99, Individual #164, Individual #52, Individual #116, Individual #50, Individual #150, Individual #10, Individual #189 - SLP Assessments for the following: - Individual #189, Individual #119, Individual #73, Individual #15, Individual #54, Individual #161, Individual #69, Individual #88 - PSPs for the following individuals: - Individual #83, Individual #84, Individual #32, Individual #112, Individual #73, Individual #6, Individual #15, Individual #23, Individual #27, Individual #100, Individual #118, Individual #152, Individual #106, Individual #22, Individual#28 - Annual Nursing Assessment, Quarterly Nursing Assessments, Health Management Plans, OT/PT Comprehensive Evaluations/Updates, OT/PT Consults, Communication Skills Assessments/Updates, SLP Consults, Nutritional Management Team progress notes, PNMP, Annual Nutrition Assessments, Nutrition Quarterly/Monthly progress notes, Dental Annual Assessment, Social History, PSP and PSP Addendums, Special Objectives and Progress Notes, Hospitalization/ER Visit documentation, 12-month weight history, OT/PT/SLP Progress Notes and Reviews, Annual History and Physical, Dining Plan, and Health Risk scores for the following

individuals:

- Individual #103, Individual #11, Individual #70, Individual #4, Individual #41, Individual #178, Individual #93, Individual #67, Individual #21, Individual #68, Individual #2, Individual #97, Individual #94, Individual #71, Individual #74, Individual #1, Individual #155, Individual #115, Individual #29, and Individual #78

Interviews and Meetings Held:

- Anderson Hicks, OTR, Habilitation Therapies Director
- Susan Acosta, MPT
- Francisco Montelongo, OTR
- Alfredo Diaz de Leon, COTA
- Jessica Cordova, MPT
- Eric Herrera, PT
- Clara Aguilera, COTA
- Sandra Moreno, PTA
- Henry Kielb, MA, CCC-SLP
- Bahola Puentes-Polo, MS, CCC-SLP
- Mary Mooney, MS, CCC-SLP
- Vicki De La O, PNMP Coordinator
- Donna Rice RD, LD
- Food Service Director
- PNMP Committee members (Nurse Case Managers and QMRPs)
- Speech technicians
- Brief conversations with food service staff and direct support staff

Observations Conducted:

- Mealtimes
- Living areas and day program areas
- HST meeting 7/21/10
- Wheelchair clinic for Individual #41 and Individual #92

Facility Self-Assessment:

Please see the Executive Summary section of this report.

Summary of Monitor's Assessment:

EPSSLC continued to use the PNMP Committee to review PNMPs during the month prior to the individual's annual PSP meeting and weight notifications. To a lesser degree, the meeting was used to review individuals who were at high risk in order to develop interventions to address PNM concerns. Documentation of the meetings had not been modified in order to more clearly track concerns and interventions through to resolution. Up until the month of this onsite review, the committee continued to

	meet only on a monthly basis, but had met twice during the month of July 2010 with plans to continue this schedule. In addition, a PT member joined at that time and was serving as a co-chair with the SLP and OT. This was a positive step, though was essentially the only change noted with regard to this process. As identified in the baseline review, this group continued to be too broad in scope and practice. They reviewed too large a number of individuals at one time such that it was not possible to effectively review all those at high risk for PNM concerns with sufficient frequency and intensity. As reported in the baseline review, the system of risk used at the facility was not effective or well integrated. Risk levels continued to be adjusted, based on the concept that, if a plan was in place to address a concern, the person was at less risk. For example, risk assignment related to aspiration was often based on whether the individual had a dining plan in place, however, based on observations of numerous errors in the implementation of those plans, individuals continued to be at great risk. It was also of concern that the monitoring system in place had not previously recognized these errors, resulting in an absence of timely and effective correction and follow-up. Unfortunately, this was very consistent with the findings during the baseline review. Staffing resources had diminished since the baseline review, though it did not appear that the existing resources had been used as effectively as possible.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included	Care for physical and nutritional needs were not consistent with current, generally accepted standards of care as per this provision item. Therefore, a rating of noncompliance was given to this provision. Details are provided below. **Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** The PNMP Committee members included PT, OT, and SLP Co-Chairs, dietitian/diet tech, nursing case managers, QMRPs, and other OT, PT, and SLP staff. Based on a review of PNMP Committee meeting documentation from 1/13/10 to 7/7/10, it was not possible to determine attendance history of team members because attendance was not documented in the documents submitted. Two different lists were submitted for PNMP Committee Members, but none was submitted for the NMC, though this was presumed to be the same. Per the two lists submitted, Committee members listed on both were as follows: • Anderson Hicks, Chairperson • Susan Acosta, PT • Henry Kielb, MA, CCC-SLP • Franciso Montelongo, OTR • Clara Auilera, COTA • Bahola Puentes-Polo, MS, CCC-SLP • Donna Rice RD/LD • Adriana Rascon Lopez, RD/LD	Noncompliance

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	as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	• Gloria Loya, QMRP Coordinator • QMRPs (6) • Nurse Case Managers (6) • Victoria De La O, PNMP Technician Supervisor Additional members listed on one of the participant lists but not both included: • Mary Mooney, SLP • Marissa Gamboa, Clerk • Jessica Cordova, MPT • Max Wiant, MD The documentation submitted did not appear to be meeting minutes, but rather a spreadsheet that consisted of a log of information reported at previous meetings. Documentation served a dual purpose as both agenda and meeting minutes and was in a spreadsheet format including name, home, last review, next review, reason for review and PNM problems, risk level, and discussion and recommendations. The agenda/meeting minutes were maintained by Victoria De La O, identified on the participant list as a PNMP technician. Previously, it had been planned that this responsibility was to be shifted to a COTA who was newly hired and a new graduate, however, this was not implemented and the responsibility had remained with the PNMP technician. Some examples of the purpose of review identified included meal refusal, emesis, coughing, hospitalization, consult findings, annual staffing review, scheduled review of aspiration risk, scheduled weight reviews, diet order changes, special consult assessment findings, swallow study results, and weight notification of loss/gain. In some cases multiple reasons were listed. The information documented previously ran together and it was difficult to track events, findings, issues, recommendations, actions, and follow-up. As described from the baseline monitoring review, the documentation was cut off in each cell so was not available to any reader. This same format was noted for the minutes for January 2010 submitted, but the format was modified slightly beginning in February 2010. Information previously reported under discussion from the current meeting was included under Reason for Review/NMC Problems while discussion and recommendations were included under a separate column. This was slightly improved and it appeared that the problem of loss of information in the spreadsheet cells had been resolved. Risk level, which was defined as "aspiration" risk only, was identified inconsistently for the individuals reviewed in the January 2010 and February 2010 documentation submitted. During those two months, there were approximately 124 individuals reviewed for something other than the weight follow-ups listed at the end, and 57% of those did not have a risk level identified. A notable improvement was evident beginning with the	

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		meeting held on 3/10/10, when omission of the risk level appeared to be the exception rather than the rule as the 61 individuals reviewed that month there were only two that failed to reflect the risk level. This continued for subsequent meetings through 7/14/10 as only three others were noted to be missing the risk level indication. It was of concern, however, that the only risk concern identified was related to aspiration and that others were not considered during these reviews. Approximately 17% of the reviews conducted were related to "aspirations risk review." It was not possible to verify the qualifications of members based on the documentation submitted. Licenses for Nurse Case Managers were not submitted, though licenses for OT, PT, SLP, and dietitian members were current. No CVs were submitted committee members, so it was not possible to verify experience or continuing education of team members. It was documented that there had been no changes in staffing, so CVs were not submitted. There had been the addition of two contract SLPs, but CVs were not submitted for them. Very limited evidence of continuing education was submitted for any committee members since the baseline review. A list of state sponsored education in 2009 was submitted and sign-in sheets for PNMP and Wheelchair Clinic Teleconferences were submitted dated 1/13, 1/20, 1/28, 3/22, 3/24, 3/31, 5/05, 5/10, 5/24, with two undated sheets. Only OTs PTs, PTAs, COTAs, and a PT technician attended these sessions. There was no evidence of continuing education for any other members. During an interview with this group, they indicated that nurses, QMRPs, and dietitians had not attended any PNM-related continuing education. During interview with the OTs and PTs, they indicated that they had attended some additional state sponsored education, though there was no evidence of this submitted and so was not verified by the monitoring team. There was no also no evidence that the EPSSLC PNMP Committee had a plan for training members specific to the knowledge-base and skills specific to their duties and responsibilities on this committee. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow-up activities, and at any phase in the Nutritional Management process. Based on a review of PNMP Committee meeting documentation, it was noted that this group had met one time monthly until July 2010 when, during the two weeks just prior to the onsite visit by the monitoring team, they had begun to meet two times monthly. It was planned that subsequent meetings were to be scheduled on the first and second	

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		Wednesdays of every month. Additional meetings, however, were not held to address urgent issues or change in status of high risk individuals, assessments, diagnostics, clinical data, or monitoring results. Based on the documentation submitted, approximately 492 individuals had been reviewed by this committee from 1/1/10 through 7/14/10. The total number of individuals reviewed each month ranged from 37 to as many as 87, with another 38 to 55 individuals reviewed related to monthly, quarterly, and bi-annual weight follow-ups through June 2010. The average number of individuals reviewed each month was 117. By report, previous meetings were chaired by an OT and SLP, though the Habilitation Therapies Director was listed as the Chairperson in the documentation submitted. At the time of this onsite review, it was reported that as of the July 2010 meetings, they were being co-chaired by OT, PT, and SLP. The meetings continued to be organized per QMRP, whereby all the individuals scheduled for review that month were discussed in a group as assigned to each of the QMRPs. Multiple Nurse Case Managers were often assigned to the individuals in each of these groups and they participated in the discussion about individuals to whom they were assigned. By report, the purpose of this Committee was to review and revise PNMPs prior to the annual PSP meetings for each individual as well as to review individuals at specific intervals based on their level of aspiration risk and to review those with weight loss or gain, change in diet orders, and other nutritional-related concerns. In reviewing meeting documentation for the last seven months, it was noted that there were 784 individuals reviewed since 1/1/10. Reasons for review were listed as follows: • Aspiration Risk Review: 75 • Weight Notifications and Reviews: 99 • Diet Order Changes: 49 • Annual Staffing Reviews: 69 These account for approximately 75% of the reviews, leaving a limited number of reviews devoted to investigation and problem-solving of physical nutritional management related concerns for those determined to be a highest risk which should be the intended focus and purpose of this committee. The aspiration risk reviews were narrow in focus and appeared to be merely an exercise rather than a means to ensure that supports and services were provided, implemented properly, and monitored and reviewed for efficacy to address health risk issues in the broader sense that may include aspiration as just one aspect. In fact as discussed with the PNMP Committee and the HST Committee during this onsite review, it was of concern that a number of individuals who had documented GERD,	

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		significant dysphagia, and/or history of aspiration pneumonia were not considered to be at high risk of aspiration merely because there was a dining plan in place or that they received a modified diet. This appeared to be common practice within the system of risk management at EPSSLC. Some examples included: Individual #71 and Individual #41, each of whom were considered to be at moderate risk as of 6/23/10. Additional examples included: • Individual #77 was described with a swallowing efficiency disorder and was "deteriorating" per the meeting documentation on 2/10/10 but because she was on a "lemon juice protocol" was "currently not at risk of aspiration/penetration." Individual #77 was observed during an evening meal and it was noted that she had not been provided "cold lemon liquids" prior to the meal and intermittently throughout as prescribed in her current dining plan. The lemon beverage had not been prepared by staff and was not on the table. She was observed banging on the table and pushing her plate away. Staff sat down with her and she accepted bites of food when presented by staff. As it was apparent that staff was not going to follow the dining plan as written, the monitoring team intervened by asking staff why she was to have the lemon liquids. The staff stated that it was to help her with swallowing. When asked when she was supposed to get them, staff responded, "Only when needed." When it was pointed out that this was not the way it was outlined in the dining plan, staff went to get the lemon beverage. It was not known how "cold" it was however, when it was offered. Clearly, despite having a plan, Individual #77 continued to be at risk for aspiration though her aspiration risk level was considered to be low as of 6/23/10. • Individual # 52 was reviewed on "1/1/10" (this appeared to be a possible error as the meeting was held on 1/10/10) following discharge from the hospital (no date or reason for hospitalization was documented) and her aspiration risk was to be increased from low to medium with semi-annual review by the Committee. It was suggested that she be reviewed the subsequent month. At that time, it was documented that she had lost weight in the hospital, her lungs were fragile and she had "aspiration/penetration problems. She was reported to be below her ideal body weight of 100 to 120 pounds, but her weight was not documented. Individual #52 was at medium risk of aspiration per the list submitted and dated 6/23/10. • Individual #105 was listed at medium aspiration risk. He was described as combative during dental visits and required sedation for treatment. He had plaque buildup and gingivitis. He also had an "infection in his esophagus" per the SLP, yet at medium risk, he was to be reviewed only two times a year. • Individual #152 was changed from low to medium risk of aspiration following an incident of emesis and was placed on oxygen scheduled for semi-annual review	

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		by the Committee. Interestingly, it was furthered noticed that he was reported to be within his ideal body weight in January 2010 at 135 pounds and again after gaining 11 pounds in one month. Recommendations were to continue with quarterly weight reviews. He was to be reviewed at least four times a year for his weight, but only two times related to aspiration risk. • Individual #78 was reviewed on 2/10/10 following an episode of emesis and coughing at night. By report from the SLP, she had long standing esophageal dysfunction, but a plan was in place via her dining plan to reduce risk of aspiration. No aspiration risk level was documented and it was determined that follow up by this committee was "not warranted." Documentation at the next meeting after additional emesis and nighttime coughing indicated that a "possible reason for episodes of emesis is related to Individual #78 not feeling well at this time." Again Committee follow-up was not recommended and a low risk designation was documented. In April 2010, she was again reviewed for emesis that the SLP attributed to medication and the nurse described as isolated. Again, follow-up was deemed unwarranted and she remained at low risk. Further emesis and consistent coughing when drinking thin liquids was reported at the meeting on 5/12/10 at which time recommendations were to complete a swallow study and an EGD, and elevate the head of her bed, and then her aspiration risk level was elevated to high. In June 2010, she continued with emesis and night time coughing. At that meeting, it was reported that the physician did not approve or write an order for head of bed elevation, but did approve a swallow study and EGD. The MBS determined that she could manage chopped foods rather than ground. Per this documentation further review would follow findings of EGD scheduled on 7/23/10 and her risk level remained at high. • Documentation for review of Individual #4 on 3/10/10 reported that an EGD was completed on 1/8/10. The SLP expressed concern for swallowing and he recommended that Individual #4 should be NPO (i.e., receive nothing by mouth). It was also reported that the family would likely have problems with this and that a PST meeting was recommended. Further recommendations were to continue current dining plan and continue with medium risk designation. No recommendations for swallow studies or other assessments were made at that time. It was reported at the Committee meeting that the PST consensus was that Individual #4 should not have tube placement because he had not had pneumonia and was at a stable weight. His PNMP was to instruct staff to permit him to eat first when it was quieter and that PT would evaluate for a larger head rest to improve head position during meals. His risk level remained at medium. During the May 2010 meeting it was discussed that Individual #4 had a number of meal refusals. His risk level remained at medium. In June 2010, additional meal refusals were reported. The SLP recommended that his risk level be increased to high with monthly monitoring by the Committee. There was no follow-up	

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		regarding change to the PNMP or head rest. Numerous meal refusals were documented in June 2010 and July 2010 and one incident of emesis. He remained at high risk per PNMP Committee documentation even though he was listed at low risk for aspiration per the HST as of 6/23/10. There were no instructions regarding Individual #4 eating first in a quieter environment in his dining plan or PNMP. A work order for higher back, humeral supports, and a wider and longer head rest was noted on 3/23/10. A mat evaluation was completed on 6/18/10, which described that these changes had been made and issued on 4/26/10. The PNMP Committee did not document that the effectiveness of this new head rest and other changes had been effective. It did not appear that sufficient investigation and problem-solving was conducted by this Committee. Data were reported and a reactionary “wait and see approach” taken. Criteria used to develop a comprehensive individual record sample of 20 individuals at risk included: • Emergency Room visits • Hospitalizations • PNMP Committee meeting documentation • Individuals with active pressure ulcer within the last 6 months • Individuals with severe dysphagia • Individuals with chronic constipation or who experienced fecal impaction within the last 6 months • Individuals with unexplained weight loss or BMI ≤ 20 • Individuals ≥ BMI of 30 • Individuals who experienced a choking incident which required abdominal thrust within the last 6 months • Individuals with a diagnosis of aspiration pneumonia • Individuals who have experienced significant falls related to transfers and/or ambulation • Individuals with chronic respiratory infections • Individuals with chronic dehydration • Individuals with a diagnosis of osteoporosis and/or osteopenia • Individuals who experienced a fracture • Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care and functional communication	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two	**Standard: A process is in place that identifies individuals with PNM concerns.** As described above, the process used to establish PNM health risks was inconsistent	Noncompliance

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	years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	across the HST and PNMP Committee and, therefore, this provision was rated as being in noncompliance. The risk levels assigned did not accurately reflect actual risk of harm to the individual as evidenced above by just a few of the many examples noted by the monitoring team. This system was ineffective and did little to heighten the awareness of potential harm to those individuals with complex and serious health risk concerns or to enhance the intensity and frequency of intervention, review, and monitoring. **Standard: Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team.** All individuals regardless of risk level received annual OT, PT, SLP, and nutrition assessments in addition to the History and Physical completed by the physician and nursing assessments in addition to others. These were discipline-specific assessments with the exception of the OT/PT assessments and little collaboration at the time of assessment was noted among professional staff for any individual and certainly not for those at highest risk. During the meetings there was often information unavailable for problem solving and decision making with regard to intervention plans and recommendations. Limited data were collected or reviewed.	
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.	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** All individuals living at EPSSLC were provided a PNMP regardless of risk level. Based on a review of an identified sample of 20 individual records, all of these individuals were provided with a PNMP. More work needs to be done in this area and, as a result, the provision is rated as being in noncompliance. Data regarding this sample are presented below. • In 20 of 20 records reviewed (100%), positioning instructions for wheelchair and alternate positions instructions were included. • In 20 of 20 records reviewed (100%), the type of transfer and, in some cases, transfer instructions were included. • In 11 of 20 records reviewed (55%), the mealtime/dining plan included oral intake strategies for mealtime and snacks. Six of the 20 individuals received all of their nutrition via gastrostomy tube and nothing by mouth, so oral intake instructions were not indicated. • In 4 of 20 records reviewed (20%), the mealtime/dining plan included	Noncompliance

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		food/fluid textures. Six of the 20 individuals received all their nutrition via gastrostomy tube and nothing by mouth so liquid consistency was not indicated. Others without a specification likely received regular thin liquids, though this was not clear from reading the plans. • In 6 of 20 records reviewed (30%), the mealtime/dining plan included behavioral concerns related to intake. Six of the 20 individuals received all their nutrition via gastrostomy tube. • In 0 of 20 records reviewed (0%), strategies for medication administration were included. • In 0 of 20 records reviewed (0%), strategies for oral hygiene were included. • In 20 of 20 records reviewed (100%), individual adaptive equipment was included. • In 19 of 20 records reviewed (95%) bathing/showering positioning and instructions were included. No bathing equipment or instructions were provided for Individual #68, but he was independently mobile for ambulation in familiar settings, transferred independently, and did not require any bathing equipment. • In 12 of 20 records reviewed (60%), communication strategies were included, though these were generally not unique to the individual but instructed staff to "supplement verbal communication with gestural cues and manual guidance." **Standard: PNM plans were incorporated into individual's Personal Support Plans.** PNMP information was typed into the PSP in the form of a "review" and approval. The PNMPs had previously been reviewed during the PNMP Committee meeting the month prior to the annual meeting. There was no evidence, however, that actual strategies from the plan were integrated into the steps and strategies for SPOs and Activity Plans, particularly as it related to communication and positioning. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** PNMPs were reviewed in the month prior to the annual PSP meeting to address revisions and included OTs, PTs, SLPs, RDs, nursing case managers, and QMRPs. By report, further discussion and review was conducted during the PSP meeting with other team members. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.**	

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		In all PSPs reviewed, there was a section that was described as review of the PNMP. Generally, however, there was only a statement that the plan had been approved rather than any real evidence of any real discussion or development and revision. **Standard: PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results.** PNMPs and dining plans were inconsistently updated. The example of Individual #4 was described above. During one observation, there were three direct support staff who attempted to offer him liquefied foods at room temperature. There were numerous others in the dining area and it was certainly not quiet, as had been recommended. It was also noted that the SLP verbalized that he had determined that staff should allow Individual #93's head to be positioned as she chose whether it was tilted laterally to the side or back in hyperextension. These instructions had not been added to her dining plan or PNMP. This was observed by the monitoring team on two occasions. A third observation by the monitoring team, showed direct support staff following the written instructions on the plan and worked to maintain her head in midline. Though PNMP and mealtime monitoring was being conducted, these issues had not been identified. Individual #21's dining plan stated, "Control the frequency that they fill ½ cup full of liquid and allow independent drinking." When staff were asked what this meant, the monitoring team got several different answers. The intent of this instruction was also unclear to the monitor and it had not been identified as a concern via mealtime or PNMP monitoring. Individual #21was observed being assisted by staff to drink her beverages at three different meals.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Standard: Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.** Based on observations of nearly 148 individuals during a meal (many in A, B, and C Dorms were observed more than once) staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan that were most likely to provoke swallowing difficulties and/or increased risk of aspiration. Therefore, this provision was rated as being in noncompliance. Examples and details are provided below. • In 33 of 148 observations, staff did not following mealtime plans. • Wheelchair positioning instructions were not specific. Limited instructions identified that individuals should remain upright, described the angle of recline, and the type of transfer to be used. General practice guidelines with regard to transfers, seatbelt use, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation and there was an expectation that direct support staff would comply. Even so, there were at least four transfers observed where staff	Noncompliance

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		completed the correct type of transfer, but used unsafe handling techniques (Individual #40, Individual #9, and two others). Inappropriate position, alignment, and support were noted for the following individuals: Individual #103, Individual #46, Individual #93, Individual #118, Individual #40, Individual #178, Individual #58, Individual #21, Individual #127, Individual #195, Individual #30, Individual #4 and Individual #92, among others. There were instances were individuals were noted in a posterior pelvic tilt, head in hyperextension, no foot rests or inadequate foot support, etc. • Alternate positioning was not observed. • Medication administration and tooth brushing instructions were not included in the PNMP. Mealtime observations revealed concerns in staff implementation of mealtime supports observed at every meal across a number of homes during the week of the onsite review. These included: • Individual #70 was to be provided jaw support as instructed when offering liquids. Staff were referred to a picture that showed him in head/neck hyperextension that potentially increased his risk of aspiration. He was listed at medium risk. He was drinking from a Wonderflo cup as directed on his dining plan, but like a number of others observed (Individual #114 and Individual #40, for example), this type of cup seemed to actually promote hyperextension rather than a more neutral alignment that would generally provide more airway protection. • Individual #4 was observed with his head tilted laterally and hyperextended while staff poured liquids from a cup into his mouth. His plan stated that Ensure should be kept out of site, but it was observed sitting on the table in full view. He was considered to be at high risk of aspiration based on review by the PNMP Committee. • Individual #40 was eating without foot support. • Individual #178 was observed without sufficient support under his feet and legs. • Individual #58 did not have foot rests on her wheelchair. She was to transfer to a regular dining chair, but this was not done prior to her meal. • It was noted that Individual #1's food sat on the table for more than five minutes before staff began to assist her to eat. Flies were landing on and around her food and utensils during her wait time. • Individual #93 was observed being assisted to eat with her head laterally tilted on her left shoulder or rotated back in severe hyperextension. Her plan indicated that staff should attempt to encourage her head in midline. • Individual #67 had been having some difficulties previously, per report of the SLP. During the observation, he commented that she was "doing well now" until	

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		the monitoring team pointed out that her plan prescribed ground foods and she was eating chopped meat. • Individual #21 was to get a small cup of liquids, half full. She was assisted to drink with her head/neck in significant hyperextension. • Eight women were sitting at the dining tables in 509 with no food available for serving. Staff reported that it would be at least another 10 minutes before the food arrived and then the plates would be prepared. • Individual #14 was eating ground foods per her dining plan. Staff reported this was due to her eating fast and coughing during meals. Her dining plan stated "no dining risks." • Individual #68 was seated at the dining table with no food in front of him, but no staff available to assist him. He was flicking his left hand at or about his face and he persisted for more than 10 minutes before staff verbally redirected him to "put your hand down." Once he was served, the food sat for at least five minutes before staff began to assist him to eat. A brown unbreakable spoon was present on the table, but was not listed on this plan. Staff stood over him to assist him. As she began to offer tomato juice that had not been thickened, the monitoring team intervened to ask what liquid consistency he was supposed to get. Staff stated that he was to get honey thickened. When asked about the nectar thick tomato juice, she replied that it was "pretty much honey." The staff's name was reported to the facility; she had been involved in an issue related to liquid consistencies during the baseline onsite review, too. The monitoring team was interviewed related to an investigation following reported abuse/neglect after the monitoring team noted unthickened liquids being served to Individual #52. • Individual #15 was to receive honey thick liquids, but was receiving pudding thick. • Individual #127 was observed eating with a posterior tilt and inadequate foot support. • Individual #9 was served Cheerios and milk, though her plan stated she was on a ground diet. When prompted to correct this, staff stated that she "eats them all the time, every morning." When the kitchen staff was asked about cereal for individuals on a ground diet, she indicated that Rice Krispies, not Cheerios was the correct choice for her diet texture type • As described above, Individual #77 had not been served cold lemon liquids before and throughout her meal. Staff failed to provide this until prompted by the monitoring team. • Individual #122 was eating regular foods per her dining plan, but was noted to stuff large amounts into her mouth at a time. Staff did not redirect her. She was listed with "choking risk" on her plan. • Individual #195 was eating pieces of bread larger than on half inch, though she	

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		was on a chopped diet, calling for food to be cut into half -inch pieces. • All the individuals living in home 510 and on chopped diets had been served breakfast rolls that were torn into 1½ to 2½ inch pieces. When this was pointed out, staff returned one individual's roll to the kitchen for further cutting, but none of the others. They were prompted by the monitoring team to correct each individual's roll. This cutting was completed by kitchen staff, but direct support staff should have recognized these errors prior to serving them. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** With the exception of home 509, all dining plans were out on the tables during the meals. When asked, all staff were able to locate the PNMPs as requested. Staff were generally appeared unsure of why they were required to implement specific strategies. Powder was added to the food of a number of individuals in the systems area and three staff were not able to state what the powder was and why it was needed. One staff working with Individual #68 offered him tomato juice that had not been thickened, though he was to have honey-thick liquids. When asked what type of liquid he was to have she was able to state "honey," but when asked about the tomato juice, she replied that "tomato juice is pretty much honey-thick."	
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.	**Standard: Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.** Competency-based training was not evident regarding this area. As a result, this provision item was rated as being in noncompliance. Review of the facility's training curricula revealed that with the exception of transfer training, much of it was knowledge-based training with little to no skills-based training. With the exception of transfer training, there were no skill competencies established. The training generally addressed these areas: • Body mechanics • Handling techniques • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Food and fluid consistency • Safe presentation techniques for food and fluid	Noncompliance

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		• PNMPs Numerous errors in implementation, however, were noted by the monitoring team and this training did not appear to be adequate or effective. **Standard: Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable.** Based on a review of staff competency-based training record documentation submitted, most documentation consisted only of sign-in sheets for participants. Evidence of pre- and post-tests were not noted. There was no evidence of performance check-offs for PNMPs including mealtime, positioning, communication plans, and other instructional plans. **Standard: All foundational trainings are updated annually**. Only transfer training was updated on an annual basis. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Staff training was conducted by professional staff and therapy technicians for supervisors and Directors of Day Program and Recreation. These staff then were responsible for training all other staff under their direction. There was no tracking as to the time frames under which the training occurred, and there were no established skill-based competencies outlined in the training for performance check off. As a result, there was no mechanism to ensure that the trickle-down training conducted by the supervisors was provided as intended by those developing the PNMPs. **Standard: PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual.** Staff training was not currently competency-based, so while staff may have received some level of training for implementation of PNMPs for those at high risk, it was not performance-based, requiring successful performance of clearly established competencies. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.**	

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		There were approximately 21 program change sheets reviewed and 11 of these showed evidence of related staff training with regard to the changes. As stated above, supervisors were to train all other staff regarding the training they had received. There were no competencies outlined for them to know what specific skills they should emphasize and expect return demonstration.	
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.	**Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no policy that related to the process of monitoring. Some general guidelines were developed and used for PNMP Coordinator. The guidelines outlined roles and responsibilities. There was no mechanism established to validate the monitors to ensure internal validity of findings across each of the Coordinators and professional staff. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** Monitoring was conducted to address mealtimes, as well as communication, transfers and positioning in the homes. While bathing and toileting equipment was reviewed for condition and cleanliness, there was no evidence of routine monitoring of transfers, positioning, and support in these. There was no evidence that monitoring of position and aspiration risk was monitored during medication administration or tooth brushing. Mealtime monitoring conducted was noted on the PNMP monitoring forms. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. There was a "Guide for PNMP Monitoring" that outlined some of the issues related to this process. The monitoring team requested OT/PT monitoring forms completed in the last month. Progress notes and other documentation were submitted in response and the monitoring team had to clarify this request. Actual monitoring tools were submitted that had been completed during the month of June 2010. There were approximately 217 forms for approximately 131 individuals submitted. This was a significant increase in PNMP monitoring conducted since the baseline onsite visit in when nearly 60% of the individuals with PNMPs had not been monitored since October 2009. Completion per home was as follows: • 506: 26 • 507:12 • 508: 18	Noncompliance

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		• 509: 23 • 510: 28 • 511: 21 • 512: 18 • 513: 12 • A Dorm: 27 • B Dorm: 14 • C Dorm: 18 There were 10 individuals monitored three times during the month of June 2010 and included: Individual #70, Individual #115, Individual #44, Individual #103, Individual #154, Individual #152, Individual #88, Individual #37, Individual #32, and Individual #120. There were 67 individuals who were monitored two times during that month. There were 54 individuals who were monitored only one time, over half of whom lived in the Systems area (Dorms A, B, C). Many of these individuals presented with a number of high risk concerns. It was of concern in many cases the individuals who were at highest risk had been monitored less frequently than many others. There were another 104 mealtime observation sheets completed and submitted. These were general mealtime observation and did not target a specific individual. General findings were as follows: • No concerns noted: 88% • Staff failed to provide adaptive mealtime equipment: 5% • Staff failed to use adaptive equipment properly: 5% • Staff failed to have food texture cards readily available: 6% • Staff failed to implement the assistance techniques per the dining plan: 2% • Staff failed to position individuals properly: .04% • Staff failed to redirect for maladaptive behaviors: .04% • Staff failed to use appropriate supplies for thickening liquids correctly: .04% • No texture errors were reported though these were noted by the monitoring team in every home observed • A number of the errors identified by the PNMP monitors were a result of installation of cameras in the homes and adaptive equipment and mealtime cards were not available. It was not acceptable that plans had not been made to ensure that each individual had the equipment prescribed in their dining plan. • When errors were identified, there was little indication that the monitor intervened and/or provided timely staff training. The COTA conducting monitoring for Individual #16 and Individual #126 did document correction and	

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		staff's "verbal understanding to their responsibility to follow the dining card." • In one case, the monitor reported that an individual who was to have hand-over-hand assistance was fed by staff with "very little self-feeding." There was no indication from the documentation that this issue had been corrected, instead a referral was made to the SLP. In another case, the monitor marked that staff had failed to redirect maladaptive behavior for Individual #90. The actual behavior was not identified and there was no indication that they had intervened to ensure that this was done for his safety, but rather made a referral to OT. • In the case of Individual #132, the monitor marked "no" for staff redirecting maladaptive behaviors. A note at the bottom stated that "staff had to redirect Individual #132 sit up when he was eating" and that he complied with their direction. This was not maladaptive. This was an example of inadequate training and validation of monitors as errors of this nature would skew the findings rendering the data ineffective. • In two cases, the monitor identified concerns related to adaptive equipment availability and use, but then stated under comments that no problems were noted. **Standard: All members of the PNM team conduct monitoring.** Habilitation Therapies staff were responsible for conducting monitoring in addition to the PNMP Coordinators. While nursing, dietitians, and QMRPs conducted some level of review relative to assessment and progress notes, there was no other coordinated system of monitoring. The current system of monitoring was not based on specific risk levels. A "hot list" had been developed by PTs to review individuals with specific concerns who required closer scrutiny and observation. This system was separate from the others, however, and did not reflect those with high health risks. The PNMP Committee monitored individuals during the monthly meetings. The method used for documentation was poorly organized and did not offer a clear statement of the issue or concern, background information, current status of the initial concern that was tracked through to resolution with actions, persons responsible and timeframes for completion. **Standard: Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.** The PNM committee did not utilize PNMP monitoring information in their reviews. The only consistent data provided and reviewed routinely was weight. There was no mechanism to track data for system analysis in order to focus training and coaching.	

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		Standard: Immediate intervention is provided if the person is determined to be at risk of harm. There was an expectation of immediate intervention when a person was determined to be at risk of harm, however, it was of concern that this was not occurring due to the number of implementation errors observed by the monitoring team.	
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.	**Standard: A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.** There was a system used by the PNMP Technician responsible for the PNMP meeting documentation to identify those who were to be reviewed at each monthly meeting. She reviewed the morning report information to determine if there had been any issues that would warrant review and if so, she placed them on the agenda. Individuals with assigned aspiration risk were reviewed once a year if they were at low risk, semi-annually if at medium risk, and monthly for high risk individuals. There was a great disparity if the interval of review between those who were high risk and those that were medium risk. Six month intervals were too long for many who presented with significant risk of this life threatening concern. Each individual was reviewed annually prior to his or her PSP in order to review the PNMP and recommend changes to it prior to the annual meeting. Additional reviews were scheduled for weight notifications, hospitalizations, emesis, etc. No additional meetings were scheduled to address pressing or urgent concerns, but rather they waited until the next monthly meeting of the Committee. None of these were related to a system of risk management that was facility-wide. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Unless there was an SPO or activity plan, there was no consistent interval of review of other supports for those individuals who presented with PNM health risk indicators.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** All individuals living at EPSSLC received an annual OT/PT Assessment and a Communication Skills Update. Each of the evaluations reviewed by the monitoring team identified those individuals who received enteral nutrition. There were four individuals in the sample of SLP assessments who received enteral nutrition and included: Individual #71, Individual #155, Individual #2, and Individual #103. In each case, a rationale for	Noncompliance

#	Provision	Assessment of Status	Compliance
	is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	continued non-oral intake was provided. There was no evidence, however, of discussion in this regard by the PST during the annual meeting. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals living at EPSSLC had been provided a PNMP and included those who received enteral nutrition. **The need for continued enteral nutrition is integrated into the PSP.** Based on a review of 20 PSPs in the individual record sample, there were six who received enteral nutrition. These individuals' PSPs did not document the rationale for the continued need for enteral nutrition. **Standard: When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used.** There were no individuals at this time being considered for return to oral intake. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** There were no facility policies defined the frequency and depth of evaluations related to an individual receiving enteral nutrition. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** In the case of Individual #4, it was noted in the PNMP meeting documentation that the SLP believed that he should not be receiving oral intake due to risks of aspiration. The PST determined that, because he had not experienced pneumonia, this was not determined to be necessary at this time. It was not apparent that the SLP had conducted special assessments at that time to gather valid data to guide his interventions and recommendations. The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, positioning and assistance techniques to ensure safe eating and drinking. As stated above however, training and monitoring of these programs failed to ensure consistent implementation.	

Recommendations:

1. Consider participation of all PNMP Committee members in routine continuing education opportunities and inservices to enhance the working knowledge of PNM issues, assessment, intervention, and review.

2. Reorganize the Committee to permit focused review on those individuals who were at greatest risk. There was no possible way that sufficient attention could be given to these individuals when such large numbers were reviewed one time a month only. As stated above, the greatest numbers of reviews were annual staffings, weight notifications and reviews, diet orders, and aspiration risk reviews.

3. Consider revision of PNMP meeting documentation to ensure ease of use to track initial problem, background information, interventions, recommendations, person responsible, dates due/completed, and outcome. Cases should be followed through resolution of the problem.

4. Incorporate findings from monitoring into the reviews to bring greater depth of information necessary for decision making and problem solving.

5. Ensure that the review process was not merely a paper trail, but rather a meaningful examination of the supports and services provided to ensure that they effectively addressed the primary presenting issue. Follow-up and feedback should be a critical aspect of the review and follow-up must continue until the problem is resolved or effectively stabilized. Risk levels should drive frequency of review, monitoring, and training focus and effort.

6. Conduct dining plan reviews for consistency of information included, clarity, and simplicity of instructions and accuracy.

7. PNMP Coordinators continue to receive specialized training, competency-based performance check offs, monitoring, and review. Establish a system to routinely validate continued competency and understanding.

8. Establish a tracking system to permit analysis and review of monitoring data.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Current Census by Home o Occupational Therapy/Physical Therapy Policy #014, 10/7/10 o Physical Nutritional Management policy #012, 12/17/09 o Nutritional Management policy #013, 12/17/09 o At Risk Individuals policy #006, 10/5/09 o EPSSLC Plan of Improvement for OT/PT o POI Supplement for OT/PT o Credentials for OTs, PTs o Sign-in sheets for Webinars (8/4/09 to 12/30/09) o HST Risk List of Individuals at Risk for Osteoporosis, Seizures, Dehydration, Aspiration, Respiratory, Weight, Constipation, Skin Breakdown o PNMPs for individuals submitted o Fall Incidents 6/1/09 to 6/23/10 o Individuals with skin breakdown 9/09 to 6/10 o Wheelchair Master list 2009 to 2010 o Mat Assessment for Seating and Positioning template o NEO training materials o List of individuals with PNM needs o RTT3 Facilitator for PT 2010 o Trial PNMP Risk Monitoring o Monthly OT/PT Report October 2009 to May 2010 o Guide for PNMP Monitoring and associated training materials o Wheelchair Clinic Work Order spreadsheet o Lifting Transfer Monitoring forms 5/10 o List of PT/OT Screenings and Referrals o List of Individuals Receiving Direct OT/PT o PNMP Monitoring forms June 2010 o PNMP training sign in sheets 1/10 to 6/10 o List of Hospital Admissions since 1/1/ 10 o New Admissions 6/1/09 to 7/20/10 o PNMP Committee documentation 1/1/10 to 7/14/10 o NMC Reviews spreadsheet o NMC Annual spreadsheet o Slip/Trip/Fall data base o List of Injuries

	o List of Falls o Individuals with BMI over 30 o PNMP Committee Meeting supporting documentation (5/12/10 and 6/9/10) including NMC Screening Tools, PNMP IPP Drafts, Nutritional Management Committee Reports o OT/PT Assessments for the following: • Individual #19, Individual #16, Individual #114, Individual #72, Individual #87, Individual #183, Individual #102, Individual #105, Individual #111, Individual #75, Individual #7, Individual #99, Individual #164, Individual #52, Individual #116, Individual #50, Individual #150, Individual #10, Individual #189 o PSPs for the following individuals: • Individual #83, Individual #84, Individual #32, Individual #112, Individual #73, Individual #6, Individual #15, Individual #23, Individual #27, Individual #100, Individual #118, Individual #152, Individual #106, Individual #22, Individual#28 o Annual Nursing Assessment, Quarterly Nursing Assessments, Health Management Plans, OT/PT Comprehensive Evaluations/Updates, OT/PT Consults, Communication Skills Assessments/Updates, SLP Consults, Nutritional Management Team progress notes, PNMP, Annual Nutrition Assessments, Nutrition Quarterly/Monthly progress notes, Dental Annual Assessment, Social History, PSP and PSP Addendums, Special Objectives and Progress Notes, Hospitalization/ER Visit documentation, 12-month weight history, OT/PT/SLP Progress Notes and Reviews, Annual History and Physical, Dining Plan, and Health Risk scores for the following individuals: • Individual #103, Individual #11, Individual #70, Individual #4, Individual #41, Individual #178, Individual #93, Individual #67, Individual #21, Individual #68, Individual #2, Individual #97, Individual #94, Individual #71, Individual #74, Individual #1, Individual #155, Individual #115, Individual #29, Individual #78 Interviews and Meetings Held: o Anderson Hicks, OTR, Habilitation Therapies Director o Susan Acosta, MPT o Franciso Montelongo, OTR o Alfredo Diaz de Leon, COTA o Jessica Cordova, MPT o Eric Herrera, PT o Clara Aguilera, COTA o Sandra Moreno, PTA o Henry Kielb, MA, CCC-SLP o Mary Mooney, MS, CCC-SLP Observations Conducted: o Mealtimes o Living areas and day program areas o HST meeting 7/21/10 o Wheelchair clinic for Individual #41 and Individual #92

	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: EPSSLC had a number of talented clinicians and the PTs, in particular, had taken a leading role in the improvement of supports and services provided. They had conducted a thorough self-analysis and developed measurable goals and corrective action plans to address many of the issues they had identified that were consistent with the findings of the monitoring team in the baseline review. More active collaboration and clinical problem solving was evident in the process used to conduct assessments across disciplines including SLPs, though this was a relatively new, but critically important, practice. Evidence of OT contributions was reduced due to the loss of a strong clinician and at the time of this review, only one OTR was employed to conduct assessments, design interventions, and to supervise COTAs. Concerted efforts had been made in the last month to implement a more thorough assessment that included clinical analysis, and that clearly stated links to health risk concerns as rationale for supports and services recommended. Emerging focus on the identification of current functional skills and potentials for learning and additional skill acquisition was noted. Previous programs that had not been integrated into the PSP with specific objectives with data collection to measure progress had been converted to SPOs, and additional new training programs had been developed. These were strong first steps in the process of establishing well-defined assessments, interventions, and implementation strategies, though most of the changes had only been developed in the weeks just prior to this review. The Habilitation Therapies Director must actively ensure that the support, tools and direction needed for the next phase of this process toward compliance are readily available.

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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	Assessments for occupational and physical therapy were evident for all individuals, however, they did not meet the requirements of this provision item, that is, they did not meet a generally accepted professional standard of care. Therefore, this provision item was rated as being in noncompliance. In addition, based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement. **Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or**	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	**experience.** At the time of this onsite monitoring review there were three PTs, all contract. One of these was full time and the other two were part time for a total of 40 hours together. There were two PT technicians. There was also one PT Assistant, a full time employee. There was only one OT and two COTAs, each full time employees. There were three OT Technicians, though one was leaving at the end of the month. One new therapy technician was expected to be assigned in August. There was a full time assistive technology fabricator and two technicians. The contract fabricator tech was expected to reduce his hours in the fall. As was the case during the baseline monitoring review, one fabricator was re-assigned and that position was still unavailable for replacement. Based on a review of documentation and interviews with therapy staff, the Department documented appropriate qualifications for OTs, PTs, and assistants with a copy of a current license for each. Review of clinical instruction documentation did not show evidence of OT/PT participation in continuing education since 1/1/10 per the list submitted, though it was known to the monitoring team that at least some of the clinicians had participated in the webinars provided by the state on a routine basis and perhaps other continuing education. The documentation submitted in response to the monitoring team's document request, however, included continuing education for the year 2009 only. Thirty-one out of 37 records reviewed (82%) described individuals who had movement disorders, and limitations in self-care and/or functional skills. There were seven of these individuals recommended for participation in physical therapy activity plans (Individual #11, Individual #71, Individual #115, Individual #21, Individual #70, Individual #97, and Individual #155). There were six individuals that were recommended for OT activity plan, including Individual #1, Individual #78, Individual #74, Individual #87, Individual #114, and Individual #72. Additional documentation indicated that there were other individuals who also received OT and/or PT programming, though the related assessments were not reviewed. These included: Individual # 90 (OT), Individual #152 (OT), Individual # 92 (PT), Individual #14 (OT), Individual # 34 (OT). All individuals were provided a PNMP and only five individuals did not receive some other type of indirect therapy supports related to wheelchair, transfers, bathing equipment, and assistive ambulation devices. A number of these also were provided adaptive mealtime equipment **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.**	

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		All individuals received an OT/PT assessment on an annual basis even if they had required supports or services during the previous year. Though the monitoring team had requested all OT/PT-related spreadsheets, there was no data tracking completion of assessments submitted. Other than the actual assessments submitted, it was not possible to verify reports that all individuals had received an annual assessment. There was a list submitted entitled Referred for Occupational Therapy/Physical Therapy that listed dates of OT/PT assessments from 1/4/10 to 6/22/10, but it was unclear whether these included all annual assessments completed during that time or only those requested in addition to the usual annual evaluations conducted for all individuals. Of the 37 assessments submitted, there were 23 identified as OT/PT Assessment Updates and 13 were identified as OT/PT Comprehensive Assessments. One evaluation for Individual #67 identified as an OT/PT New Admission was dated 5/14/10 and 5/30/10, however, the individual was not included on the list of new admissions submitted as requested and had received an OT/PT assessment the previous year. There were two individuals reported as new admissions since the baseline onsite review, Individual #161 and Individual #191. The assessment for Individual #191 was not requested. The OT/PT assessment for Individual #161 was identified as completed on 5/20/10. This was outside the 30 day time period for completion of an assessment within 30 days of admission by one day only. This assessment, however, occurred after the PSP meeting was held on 5/17/10 and, as a result, no information was available to the PST during the meeting. Individual #161 was not recommended for OT or PT services according to this list submitted. There were two assessments submitted for Individual #68, one dated July 2009 and another from July 2010. Per interview with the clinicians, they described a process using font colors to differentiate the clinicians when writing the draft report. The assessment update from July 2010 appeared to be a draft, while the other was a final, but outdated report. Drafts were requested for OT/PT evaluations for the following: Individual #111, Individual #105, Individual #97, Individual #102, Individual #75, Individual #7, and Individual #99, as well as for Individual #68. Again, in response to this request, only assessments from 2009 were available for these individuals. It was unclear then how the one draft was submitted. The assessment submitted for Individual #67 and Individual #115 also appeared to be in this draft form. For 27 of 37 individuals reviewed, OT/PT assessments were current within the last 12 months. Seven that were not current had expired earlier in the month of this onsite review in preparation for PSPs to be held during the month of August. These included the individuals identified above for whom drafts were requested. Three other assessments appeared to be in draft form and as such would not be considered current.	

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		Additional screenings and assessments were completed for a number of individuals and seemed to be related to a specific issue, such as needs for adaptive equipment, padding for existing equipment, specialized chairs, falls, and other concerns based on referral or request outside of the annual assessment provided. These were brief notes in SOAP format, were not comprehensive, and did not address any other concerns outside of the specific request. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** When a referral was received, the OT and PT clinicians conducted a specific assessment directly related to the concern identified in the referral. A comprehensive assessment was not conducted at that time or within 30 days because all individuals received an assessment annually whether or not they received supports and services from OT or PT. **Standard: If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status.** Each individual living at EPSSLC received an annual assessment regardless of whether or not he or she had received supports and services during that year. There did not appear to be any discernible difference in content between the OT/PT Assessment Update and the OT/PT Comprehensive Assessment. As cited previously, many of these were not comprehensive in that they lacked information regarding medical history, health risk indicators and limited clinical analysis with rationale for recommendations. A new format was developed in an effort to address these deficiencies, though it had been implemented just prior to the onsite review by the monitoring team. Though drafts of these initials reports were requested they were not submitted, and it was stated that there were only 2009 assessments available. Even so, a completed assessment for Individual #4 dated 6/18/10, and a draft of an evaluation for Individual #68 dated 7/8/10 were submitted. Further analysis of this new assessment format and process will be necessary during the subsequent onsite review in 2011. Screenings or single focus assessments were completed per referral or request and post hospitalization. There was not consistency as to which was completed because in some cases there was a post-hospitalization screening and, in other cases, there was a brief post-hospitalization assessment, and each was completed by OT, but not PT. Based on record review of 37 individuals, 73% of those receiving direct and/or indirect OT/PT services had received a comprehensive OT/PT assessment or assessment update within the last 12 months. As stated above there was no discernible difference between these two assessment types.	

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		Generally, each of the following areas were addressed in both the Comprehensive Assessment and Assessment Update: • Movement; • Mobility; • Range of motion; • Independence; and • Functional Status across each of these areas (HCG VIII.B.2) Based on record review of 20 individuals, a post-hospitalization screening was completed by OT, most within 24 to 48 hours of discharge. There was no evidence of a similar type of review by PT. A more comprehensive OT/PT assessment was not conducted subsequent to the screening, though recommendations were made at the time of the screening as indicated. In one case, there was a screening recommendation (2/5/10) post-VNS placement for seizure management that OT should complete an assessment for Individual #115 upon his return to his home. There was no evidence that this was done because the subsequent screening assessment submitted was dated 3/23/10 following another hospitalization for possible pneumonia. **Standard: Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral.** As stated above, all individuals received an annual assessment regardless of whether or not they received OT/PT supports and services. It appeared that some of the individuals were screened upon discharge from the hospital, though there were a number for whom screenings were not submitted for hospitalizations identified on the list submitted by the facility to the monitoring team, including Individual #1, Individual #71, Individual #29, and of two hospitalizations for Individual #74 with a discharge diagnosis of aspiration pneumonia on 6/5/10. Others were referral based and focused on a specific concern and a brief note was written in SOAP format. **Standard: Findings of comprehensive assessment drive the need for further assessment, such a wheelchair/seating assessment.** As described in the baseline review of EPSSLC, most of the assessments did not identify the effectiveness of adaptive equipment or assistive technology and this continued to be true at the time of this review. The assessment for Individual #4 was of a new format and offered a rationale for equipment including his wheelchair. A mat evaluation and review of the wheelchair was an aspect of the annual assessment and it was determined that in the case of Individual #4, it was deemed to be appropriate for him and further assessment or modifications were not indicated at that time. He was considered at high	

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		risk of aspiration. He was described as maintaining his head in neutral during a mealtime observation. During a mealtime observation by the monitoring team, however, it was noted that staff had significant difficulty with Individual #4's head position in his chair while assisting him to eat. The lack of rationale and review of condition, fit, and function as a part of each assessment was noted in other assessments. This new process should result in improvement in this area and further review will be necessary in the future. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** One (Individual #4) of the 37 assessments reviewed addressed medical issues and health risk indicators identified via a plan, support, or service or, if not, provided rationale these were not indicated. By report, there was a plan to implement a revised assessment format to ensure that these issues would be addressed consistently. As was previous identified during the baseline onsite review as well as during this current review, the system of identifying risk was inconsistent throughout the facility. The NMC had an established mechanism to identify risk, as did the HST, and the OT/PT clinicians had yet another method. It would be critical that the facility adopt a mechanism that was consistent. The therapy clinicians should participate in the processes required to identify and mitigate risk, and document this clearly in their assessments, intervention plans, training, and other documentation. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** Based on review of 37 OT/PT assessments, 38% included signatures of both OT and PT. Two of these were assessments completed by Amy Gleaton, OTR, previously employed at EPSSLC, but the signatures were by Francisco Montelongo, OTR. The signatures were not dated, but there were dates of completion for the OT and PT portions of the assessment on the front page of the assessment. Half of these were completed on the same date or dates; the other half documented OT and PT conducting the assessments on different dates. During interview with therapy staff, this issue was discussed. A new process had been implemented in which the clinicians met prior to the assessment to determine what aspects of the assessment would be critical to complete together and this was scheduled. Other areas would be evaluated by either the OT or PT and could result in multiple assessment dates or create a "range" of dates in which the assessment was completed. This was considered by the clinicians to be a more efficient use of their time. In addition,	

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		the draft reports were written in collaboration, using font colors to differentiate input by each of the clinicians, then were to be finalized prior to submission for the PSP. As described above, there were three of what appeared to be draft reports submitted as final with the document request (Individual #67, Individual #115, and Individual #68). In Individual #68's report, the clinicians had outlined their rationale for collaboration in a section titled "Pre-Update Meeting" in the report dated 7/8/10. Based on review of 37 OT/PT assessments, only the assessment for Individual #4 described above, dated 6/18/10, clearly established active collaboration between OT and PT. The Integrated OT/PT Collaborative Summary section of the new assessment format was an effort to identify personal preferences and functional abilities as well as potential for skill acquisition and barriers to skill performance upon which to base the PNMPs, activities, and therapeutic interventions. There will be learning curve for all of the clinicians to refine this process, but they should be commended for their thoughtful efforts.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Although actions were being taken, further work will need to be done to ensure that occupational and physical therapy plans are created and implemented in a manger that is individualized and that has appropriate types of measureable outcomes. Therefore, this provision item was rated as being in noncompliance. **Standard: Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP.** This was difficult to assess for some of the individuals in the sample because the PSPs submitted were expired. These included the following with PSP dates in parentheses: Individual #70 (2/3/09), Individual #74 (10/23/08), Individual #67 (6/22/09), Individual #115 (6/22/09), and Individual #178 (3/10/09). While there were a number of OT and/or PT Activity Plans in place, these were not typically noted in the PSP. By report, there had been a significant push to implement a greater number of Specific Program Objectives (SPOs) as well as to ensure that Activity Plans were integrated in the PSPs. In some cases development of these plans and their implementation were not completed within thin 30 day time frame as required. An example is described below: • In the case of Individual #78, an OT/PT Assessment was dated 9/15/09 for PT and 8/26/09 for OT. Her PSP meeting was held on 9/15/09. A recommendation stated that OT was "in the process of completing sensory evaluations" and was to have recommendations with "likely formal programming." A brief OT Assessment Update on 1/22/10, nearly five months later, outlined the need to implement a Sensory Processing Activity Plan to promote adaptive behaviors to reduce targeted self-injurious behaviors, to provide a less restrictive environment, to establish a baseline of sensory needs and to improve her level of	Noncompliance

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		function. This note indicated that, though the OT assessment had been completed on 8/26/09, the sensory evaluation report was submitted over two months later on 10/28/09, more than one month after the PSP. This assessment was not submitted to the monitoring team, though all OT/PT assessments had been requested for Individual #78. There was no other documentation as to the specific findings. This OT note further stated that the OT had made general recommendations of strategies for working with Individual #78, though there was no evidence of staff training, nor were these strategies noted in her PNMP or PSP. It was also reported by the OT that since the time of the report, Individual #78's behavioral concerns had escalated, requiring updates to the PBSP and Safety Plans. As a result, an OT Activity Plan was developed for implementation on 1/25/10. It was of great concern that, although the OT indicated in August and September 2009 that she was aware that Individual #78 would likely require direct OT services to address sensory processing concerns, actual intervention was not initiated for almost five months and only after behaviors had "escalated." A purpose was established for the activity plan, but no measureable outcomes were outlined in the activity plan to be implemented five times a week for four weeks. After review of the plan on 2/22/10, it was extended for an additional eight weeks due to perceived efficacy. Baseline of her behaviors and performance was not described in the note and no assessment was available for review. Extensive notes were written by the COTA with regard to this plan and, by report, it continued to be implemented at the time of this onsite review. During discussion with the COTA, it was determined that a baseline of her behavioral concerns was not known to OT and that actual efficacy in that regard could not be determined. While anecdotal reporting appeared to suggest that "improvements" had been noted, there were no data to support this. This COTA was devoting significant time and energy into this plan and specific goals and data collection methods should be developed. **Standard: Within 30 days of development of the plan, it was implemented.** The plan described above for Individual #78 was implemented within 30 days of plan development. Most of the other plans had been ongoing and it was difficult to track when they were initially implemented. Extensive documentation was submitted for plans provided to Individual #78, Individual #87, Individual #72 and Individual #114. Documentation for other plans was not submitted. **Standard: Appropriate intervention plans are: integrated into the PSP,**	

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		individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes. There was no evidence of SPOs for OT or PT in the PSPs submitted. By report, this was an emerging process. In some cases, examples of SPOs were submitted for review but the PSPs were not available as was the case for PT SPOs for Individual #60 and Individual #30. The purpose of the activity plans was stated, but there were no measureable goals or objectives noted with the exception of two SPOs submitted. Frequency and duration of implementation was listed as well as the staff responsible, however, data collection was via a daily note. The notes reviewed varied in detail and were narrative only, so tracking actual performance data would be difficult. Emphasis on progress related to a specific measurable objective should be clearly and consistently stated. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** PNMPs and intervention plans addressed areas related to positioning, transfers, range of motion and mobility, but less so related to promoting independence and skill acquisition. One plan addressed functional writing, another on mobility skills in a power wheelchair. There was a poverty of intervention plans beyond the PNMP. These plans included staff instructions or precautions in the areas of mobility, transfers, movement techniques, bed and other positioning, bed mobility, and bathing, in addition to listing assistive equipment, communication, and the dining plan. There was little information that identified how the individual was able to participate or ways in which skill acquisition and practice could be incorporated into the individual's daily routine. These strategies promote teachable moments throughout the day and should be included in training, monitoring, coaching ,and modeling conducted by the therapy staff. This greatly enhances opportunities for learning and independence. Many of these may be as subtle as allowing sufficient time for the individual to give a signal that he or she was ready for a transfer (e.g., 1-2-3-GO) in that the individual may be able to blink, vocalize, or nod his or her head on "GO." Or, the individual may be able to look in the direction of the transfer for example by looking over to their bed right before the transfer from their wheelchair. Other examples are below: • the individual may be able to hold his or her foot up for placement of shoes and socks, • during mealtimes, when an individual who received hand over hand assistance had the ability to bring the spoon to his mouth and only required assistance to scoop, and	

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		• an individual could hold a second toothbrush or hairbrush in her hand or on her lap while being assisted to have teeth or hair brushed. These subtle abilities or potentials for skill acquisition often go unnoticed by direct support professional staff as they hurry to get everything done across their day. These types of activities would require that a baseline be established with regard to the individual's ability at the time of the OT/PT assessment and then supports would be established to provide opportunities for practice of existing skills or for learning new ones. The clinicians appeared to recognize that more work was needed in this area. The new assessment format had sections in each assessment domain that addressed "potential for skill acquisition" developed based on dialog with the monitoring team during the previous review. They reported to have been also converting a number of their activity plans to SPOs with measurable objectives, however, the number of individuals for whom plans were developed had not significantly increased since the previous onsite review. **Standard: The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The rationale offered in the assessment, however, was generally insufficient. The new assessment format included sections to provide analysis and rationale for equipment, such as the wheelchair rather than a rote assignment of these systems without clear and well documented regard to functional abilities, potentials, and health risk indicators. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** In discussion, with the PTA and COTA regarding rationale and justification for existing plans for which they were responsible, they were generally able to discuss the parameters of these plans. Actual measureable goals, however, were uncommon in the design of most of the plans and, as a result, they had difficulty quantifying progress. It was noted that the clinicians generally also did a good job of verbalizing their clinical thinking throughout the process of mat evaluation to problem solve seating concerns for Individual #92 and Individual #41, for example. The assistants who participated were exceptional in analysis of this nature and making suggestions to remedy problems noted. **Standard: On at least a monthly basis or more often as needed, the individual's**	

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		OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. Narrative documentation was extensive by the OT assistants related to plans for which they were responsible. Documentation of monthly review by the OTR was not consistent based on that submitted. There was very limited evidence of documentation related to activity plans or SPOs by PT staff. In the absence of measureable objectives, data collection was difficult and as a result assessment of progress was difficult as well. Subsequently, continuation of, changes in and termination of the plans were not clearly justified. As of September 1st, professional staff were to be more involved in routine monitoring of the PNMPs.	
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.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, implementation by staff was not consistently performed as intended per the PNMP. Therefore, this provision item was rated as being in noncompliance. Some examples are presented below: • Individual #103: Her lap tray had been placed by staff with the left side high and the right side low. Her trunk was leaning significantly to the right and she was not repositioned by staff before the added the tray. Individual #103 used supplementary oxygen and, therefore, position was critical to ensure adequate oxygenation. • Individual #40 did not have foot support during her mealtime on two occasions. • Individual #58 was seated in her wheelchair without foot rests. She was not transferred to a regular dining chair prior to her meal. • Individual #118 was positioned in her wheelchair with her upper legs inadequately supported. • Individual #2 was observed wearing bilateral palm protectors that were around her wrists only and not positioned properly into her palms. • Individual #127 was positioned in posterior pelvic tilt and her feet were not well supported on the foot rests during a meal. • A number of individuals were observed wearing gait belts while sitting (Individual #195, Individual #12, among others). • Individual #9 was seated in a wheelchair secondary to a foot injury. Her right ankle was swollen and there was discoloration of her foot and lower leg. There were no foot rests on the wheelchair and no means to elevate her feet and legs. When she was transferred to a regular chair for her meal, and when staff attempted to move the chair up to the table, her foot was bumped into the table	Noncompliance

#	Provision	Assessment of Status	Compliance
		base. The direct support professionals then transferred her back to the wheelchair and when prompted by the monitoring team, the staff added the foot rests. • Individual #195 was observed seated in a wheelchair without foot rests. Staff reported that they did not use them inside the home, only outside. • In a number of cases, staff did not provide adequate time for the individual to bear weight on their lower extremities during a stand pivot transfer. (Individual #195). **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The only competency-based OT/PT training aspect of new employee orientation was provided related to transfers and this was the only area for which annual re-training was provided. There was a list of individuals who had completed this training and there were specific checklists used for this process. It was unclear as to the actual standards of performance for skills required. While mechanical lift transfers observed were generally acceptable, a number of the stand pivot transfers were poorly executed by staff and suggested that the original training and annual re-training was inadequate and that monitoring did not effectively identify the need for further training and coaching. Clinicians and PNMP coordinators provided person-specific training for transfers and positioning or other interventions (e.g., orthotics, gait trainers, gait belt, mealtime chairs, bathing trolleys, toileting chairs and seats) that varied from that taught in NEO to Supervisors, Director of Pre-Vocational Services, Director of Recreation, the QMRP and, at times, nursing staff. Supervisors and Directors then in turn, trained their staff. There was a plan to be implemented by Habilitation Therapies that plans requiring training would outline specific competencies as part of their training with the expectation that supervisors would use the same competencies to check off the performance of their staff as well. At the time of this onsite review, however, evidence of training was limited to sign in sheets that did not outline the skills or performance criteria expected and, as such, would not be considered to be competency-based. **Standard: Staff verbalizes rationale for interventions.** In the examples above, staff clearly were not able to recognize the rationale behind recommended interventions. Rationale for interventions and supports was not consistently included in the PNMP. This would be an important aspect of staff training as well as monitoring and coaching.	

#	Provision	Assessment of Status	Compliance
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.	The monitoring as required by this provision item was fraught with problems (described below) and will need attention from department managers. **Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The current system of PNMP monitoring was generally limited to availability and condition, rather than function and fit. These were consistently reviewed on an annual basis and upon referral when a problem was identified. Proactive review and monitoring was not yet in place, but a plan was in development to address this. Implementation of this will be reviewed in further depth during a subsequent onsite review. The fabricators conducted maintenance checks on a quarterly basis for wheelchairs only. Direct support professionals were responsible for conducting daily maintenance checks and cleaning of all equipment. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** As stated above, monitoring typically was limited to availability and condition of equipment rather than efficacy of the interventions. This was to become integrated in a system of PNMP monitoring conducted by the professional staff on a routine basis. As described above, there appeared to be monthly review of activity plans and/or SPOs, but documentation of this was not consistent and only a limited amount was submitted to the monitoring team in the document request materials. An additional system of monitoring was implemented that involved review of individuals on a "hot list" as designated by a licensed OT or PT. Technicians and Assistants conducted monitoring of these individuals considered to be at high risk or presenting with urgent needs requiring close follow-up. There were no specific indicators for the monitors, but they were to enter a narrative report of their findings. Early attempts were less than informative so documentation requirements were to be better outlined by report. **Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.** There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation or follow-up and communication of findings. There was a	Noncompliance

#	Provision	Assessment of Status	Compliance
		Guide for PNMP Monitoring that outlined some of the issues related to this process. The monitoring team requested OT/PT monitoring forms completed in the last month. Instead, progress notes and other documentation were submitted in response and the monitoring team had to clarify this request. Actual monitoring tools were submitted that had been completed during the month of June 2010. There were approximately 217 forms for approximately 131 individuals submitted. This was a significant increase in PNMP monitoring conducted since the baseline onsite visit in January 2010 when nearly 60% of the individuals with PNMPs had not been monitored since October 2009. Completion per home was as follows: • 506: 26 • 507:12 • 508: 18 • 509: 23 • 510: 28 • 511: 21 • 512: 18 • 513: 12 • A Dorm: 27 • B Dorm: 14 • C Dorm: 18 There were 10 individuals monitored three times during the month of June 2010 and included: Individual #70, Individual #115, Individual #44, Individual #103, Individual #154, Individual #152, Individual #88, Individual #37, Individual #32, and Individual #120. There were 67 individuals who were monitored two times during that month. There were 54 individuals who were monitored only one time, over half of whom lived in the Systems area (Dorms A, B, C). Many of these individuals presented with a number of high risk concerns. It was of concern that, in many cases, the individuals who were at highest risk had been monitored less frequently than many others. General findings were as follows: • No concerns noted: 53% • Staff failed to initial PNMP log sheet: 25% • Equipment was available, clean and/or in good working condition: 17% (This included communication equipment, eyeglasses and OT/PT assistive equipment. 22 individuals had OT/PT equipment that was missing, dirty, worn or broken). In three instances, the monitor did not specify what equipment was missing, unclean, or not working. • Staff were not following schedules per the PNMP: 5% (Reasonable rationale was provided in most cases).	

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		• PNMP sheets were not current and/or unavailable in the training book: 2% • Assistive equipment photo sheet current and consistent with equipment used: 8% • Inappropriate use of seatbelt, sling, or repositioning in wheelchair: 2% (In one case staff were asked to reposition the individual and reminders to wear gloves or palm protectors were reported) Interestingly, in all cases, monitors reported that transfers were either "performed" correctly or "described" accurately. In all cases, it was reported that staff "acknowledged being trained on the correct use of equipment." • There were 45 monitoring sheets that identified this indicator (#5) as "not applicable" and in some cases stated that the individual was independent. There were 79 monitoring sheets that indicated staff had "described" proper transfer techniques. There were 57 sheets that reported staff had "demonstrated" proper transfer techniques. • An additional 18 sheets documented that the transfer was used properly, but did not clearly specify if this was described or performed. • There were eight forms that did not score this element. • Eight forms were marked "A" with no specification as to "described" vs. "performed." • One other form was marked "D," again, with no specification as to "described" or "performed." These scores were not defined and were inconsistent with all other forms and would not be considered valid. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** The system of monitoring was relatively new, the monitors were not adequately trained and there was no tracking system to analyze and report findings to drive needed staff training and to ensure system change as indicated. The PNMP Coordinators had received some classroom instruction with regard to the process and had attended the standard new employee training, but had not been observed during monitoring with validation to ensure competency with regard to content, documentation, follow-up, and so forth in order to reinforce training, establish competency, and ensure continued competence of the monitors, as well ongoing integrity of the process and the data collected. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** See above.	

#	Provision	Assessment of Status	Compliance
		Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff . This was reported to be true by therapy clinicians though since training was not competency-based there was no assurance that those who were most at risk were assisted by competent, well-trained direct support professionals. A number of stand pivot transfers were observed to be unsafe and/or did not promote individual participation or skill development. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There was no documentary evidence that issues identified during monitoring had been remedied or that home supervisors were notified of the findings. There was no tracking system to enable systemic analysis of findings or to track follow-up. **Standard: Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.** By report there was back up equipment in both the homes and Habilitation Therapies to ensure that in most cases, items were available as needed at all times. Use of foot rests or support was noted in a number of cases as described above, however, in each case, the equipment was available, but not appropriately used. The technicians maintained an inventory of smaller equipment and track when re-ordering is necessary. **Standard: Data collection method is validated by the program's author(s).** While the OTR or PT were to review notes written by the activity plan or SPO program implementer monthly, there was not consistent evidence of this in the documentation submitted.	

Recommendations:

1. OT staffing was inadequate and aggressive recruitment was indicated to ensure adequate supports and services were available to those with OT needs. The COTAs currently employed appeared to be strong, but would benefit from consistent supervision and direction from OTRs.

2. As was noted during the baseline onsite review, a number of individuals did not have current PSPs available in the record. Current PSPs need

to be available in the record.

3. Investigate whether the assessments for Individual #115, Individual #67, and Individual #68 were in draft format or if they were intended to be final.

4. PNMP Coordinators continue to require structured, functional competency-based training to include didactic presentation of monitoring strategies and validation of competence through a "monitor the monitor" process whereby they are observed during the monitoring process and validation of findings compared with a licensed clinician.

5. The "hot list" system was an effort to identify those with urgent concerns requiring close oversight, however, the department should ensure that they do not create another layer of risk with a separate system of monitoring so as to further complicate the process. Consideration of methods to integrate systems will ensure improved integrity of data collected, more prompt response time to remedy issues identified and better control over follow-up and tracking.

6. Continue to develop and improve assessment strategies. These appeared to be moving in a positive direction (e.g., collaboration, analysis of findings, rationale for intervention) and will require diligent effort to try them out, ensure that documentation accurately reflects the process and result in positive outcomes that are meaningful, functional and measureable.

7. Ensure that performance competencies are clearly defined for staff training that is skills based. Additional training of supervisors and day program directors may be needed to ensure that they have the skills they need to train others and understand how to establish competent skill performance.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o Dental Policy and Procedure Manual, Revised 9/1/09 o EPSSLC Dental Data, 1/09 – 5/10 Interviews and Meetings Held: o Jennifer Pacheco, RDH o Raquel Rodriquez, RDH o Anderson Hicks, Habilitation Services Director o Ken Wiant, M.D., Medical Director Observations Conducted: o Dental clinic
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: The facility was providing annual dental assessments. Actual treatment provided was limited and consisted primarily of cleaning. Relatively few restorative procedures were being done and x-rays were seldom done. Dental appointments were rarely completed without some sort of restraint. Overall, minimal services were being provided above hygiene, and restraints were being used frequently.

#	Provision	Assessment of Status	Compliance
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	The facility opened the new dental clinic in May 2010. It was staffed with two registered dental hygienists. One was a full-time employee and the other worked full time on contract. They were supervised by the medical director. The clinic had a dentist for two to three weeks in May, but there was no dentist at the time of this onsite monitoring review. A dentist from another SSLC had conducted a few clinics. The facility was currently negotiating a contract with a local dentist. In September 2009, the facility implemented a comprehensive set of dental policies covering areas such as provision of services, training, and infection control. The medical director reported that these policies were adopted from another DADS SSLC.	Noncompliance

#	Provision	Assessment of Status	Compliance
	guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The requirement to have regular dental assessments was being met. Data (1/09 to 5/10) provided by the facility showed that 100% of the individuals had an annual dental assessment and some level of preventive care. There was evidence of this in the records reviewed. Restorative treatment was seen in only 33 (26%) of the 125 individuals with teeth. Twenty individuals (16%) had tooth extractions and two individuals had dental emergencies. Of the seven individuals listed below, none received any treatment beyond cleaning. There are also examples of inconsistency in oral hygiene status reported by the dentist and the RDH. In those instances where hygiene was poor, the clinic note did not provide any specific direction to the teams on treatment. • Individual # 78: o 4/2/2009 Annual • "Looks good today" o 12/15/09 • Oral cavity exam - normal • Not able to get x-rays • Prophylaxis and exam with 3 aides • Individual #1 o 7/14/10 • Exam, very tenacious calculus • Individual #2 o 12/3/09 Annual • Oral cavity exam - normal • Exam and prophylaxis in chair with one aid • Big gagger *The AMS documented chronic gingivitis by MD. The RDH assessment documented periodontal disease. o 5/19/10 • Oral cavity exam – normal • Unable to get x-rays • Exam and prophylaxis in chair • RTC 3 months *The RDH assessment on 4/23/10 documented periodontal disease with heavy calculus and plaque. • Individual #16	

#	Provision	Assessment of Status	Compliance
		o 8/11/09 • Oral cavity exam – normal • Exam and prophylaxis in chair • Heavy tartar *The RDH assessment on 9/11/09 documented moderate gingivitis with red and bulbous gum tissue • Individual #54 o 2/8/10 Annual • Exam and prophylaxis • 4 x-rays - ok • Abnormal gums • Individual #100 o 1/13/10 Annual dental with sedation • 2 x-rays (no results) • Exam and prophylaxis with N20 • Individual#47 o 3/29/10 Annual with sedation • X-rays – not done • Oral exam – normal • Exam and prophylaxis • Looks good today	
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	The facility had policies and procedures in place. It also had a fully equipped dental clinic. There currently was no dentist to provide services. Two full time hygienists provided hygiene services. It appeared that some of the operational procedures had not been fully implemented. For example, the manual contained requirements for hygiene documentation that required each individual to have his or her hygiene status documented at each appointment. The ratings of good, fair, and poor, and the associated criteria were outlined. The dental notes included in the records did not utilize this system. The dentist classified each individual's oral cavity as normal or abnormal. The dental notes in the records reviewed did not provide adequate information to the teams about an individual's hygiene status. The documentation of dental visits was very brief. There was often a substantial	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	difference in ratings of hygiene by the RDH and the dentist, even when appointments were in close proximity. The records reviewed did not include any thoughtful discussion on the use of protective supports, desensitization, and other approaches to overcome barriers that limited the provision of services. The notes did not provide any guidance from the dentist on 1. oral hygiene care in the homes, 2. additional treatment when oral hygiene was inadequate, or 3. recommendations for staff training and monitoring.	

Recommendations:

1. The facility must rigorously pursue services from a contract dentist.

2. The types of services provided should be expanded such that those individuals who can benefit may do so.

3. The use of protective supports in dental clinic should be examined. If not already being done, all individuals who have required protective supports should be assessed for the appropriateness of a desensitization plan.

4. Dental notes should include a hygiene status assigned by the dentist using the criteria outlined in the dental manual. Inter-rater reliability should be established with the hygienists.

5. Any individual with a poor hygiene rating or deterioration in hygiene status should have an individualized dental plan of care implemented.

6. Staff should be trained on the plan and it should be verified that staff understand the plan and have implemented the plan.

7. The dental clinic should develop a quality improvement program in conjunction with the overall facility quality efforts.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance** <u>Documents Reviewed</u>: o Current Census by Home o Communication Services policy #016, 10/7/09 o EPSSLC Plan of Improvement for Communication o POI Supplement for Communication o Credentials for SLPs o PNMPs for individuals submitted o Communication dictionaries for all individuals submitted o AAC/Communication Book Monitoring Spreadsheet 2009 to 2010 o SLP Annual Communication Assessments and AAC Devices spreadsheet o AAC/Communication Assessment Report template o Wheelchair Master list 2009 to 2010 o Mat Assessment for Seating and Positioning template o NEO training materials o Guide for PNMP Monitoring and associated training materials o New Admissions 6/1/09 to 7/20/10 o PSPs for the following individuals: • Individual #83, Individual #84, Individual #32, Individual #112, Individual #73, Individual #6, Individual #15, Individual #23, Individual #27, Individual #100, Individual #118, Individual #152, Individual #106, Individual #22, Individual#28 o SLP Assessments for the following: • Individual #189, Individual #119, Individual #73, Individual #15, Individual #54, Individual #161, Individual #69, Individual #88 o Annual Nursing Assessment, Quarterly Nursing Assessments, Health Management Plans, OT/PT Comprehensive Evaluations/Updates, OT/PT Consults, Communication Skills Assessments/Updates, SLP Consults, Nutritional Management Team progress notes, PNMP, Annual Nutrition Assessments, Nutrition Quarterly/Monthly progress notes, Dental Annual Assessment, Social History, PSP and PSP Addendums, Special Objectives and Progress Notes, Hospitalization/ER Visit documentation, 12-month weight history, OT/PT/SLP Progress Notes and Reviews, Annual History and Physical, Dining Plan, and Health Risk scores for the following individuals: • Individual #103, Individual #11, Individual #70, Individual #4, Individual #41, Individual #178, Individual #93, Individual #67, Individual #21, Individual #68, Individual #2, Individual #97, Individual #94, Individual #71, Individual #74, Individual #1, Individual #155, Individual #115, Individual #29, and Individual #78

	Interviews and Meetings Held: o Anderson Hicks, OTR, Habilitation Therapies Director o Henry Kielb, MA, CCC-SLP o Bahola Puentes-Polo, MS, CCC-SLP o Mary Mooney, MS, CCC-SLP o Speech technicians Observations Conducted: o Mealtimes o Living areas and day program areas o Wheelchair clinic for Individual #41 and Individual #92
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Very limited progress in this area was evident since the previous review, though on a positive note, the facility had recently begun to contract with two strong clinicians with expertise related to AAC and communication. For most of this time, however, there continued to be only one clinician. Assessment formats and content related to communication had remained essentially unchanged until the month just prior to this onsite review. The sections for AAC did not reflect thorough and knowledgeable review of individual needs, and recommendations were rote and generally limited to continued use of the communication book and wallboards available in the homes. Other devices provided continued to be scheduled for use rather than available at times throughout the day and across environments. There was no increase in the availability of AAC systems to other individuals who would benefit. During the last month, however, there had been partial implementation of an expanded assessment for AAC and communication-related behavior concerns. One of the contract therapists had initiated a process of assessing 12 individuals with greater need in order to design and implement appropriate AAC systems, including sign language. While these were seen as positive first steps, merely adding sections to a written report will not effectively ensure that the appropriate AAC systems are identified and provided to those who need them. There did not appear to be a clear system of establishing priorities based on need for those who were nonverbal and those with communication-related behavior concerns. The two contract clinicians appeared to understand the process of functional design of these systems and they should play an important role in ensuring greater progress in this area during the next six months. Concerted effort should be directed toward continued recruitment of additional professional and technician level staff.

#	Provision	Assessment of Status	Compliance
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.	At the time of the onsite monitoring tour, there were not sufficient speech pathologists or other professionals to meet the requirements of this provision item, therefore, it was rated to be in noncompliance. Further, based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement. **Standard: The facility provided an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. Training included augmentative and assistive communication.** There was one full time SLP employed (Henry Kielb, CCC/SLP) and two recently hired part time contract SLPs, as well as one speech technician assigned to the Speech Department, and one other technician with part time assignment to Speech. Mary Mooney, CCC/SLP had been providing full time services during the summer, but was to return to her full time position in mid-August. She had agreed to continue on a very part time basis throughout the school year and would consider more permanent contract employment upon retirement from her teaching position in the next year or so. By report, the other part time SLP was considering providing more contract hours beginning in mid-August rather than returning full time to her position in the school system. Per Andy Hicks, Director, he was discussing further contract positions with a speech assistant (three quarter time) at the time of this onsite visit. Per staff report, they were not currently able to provide supports and services based on individual needs at this time due to inadequate staffing. The full time SLP had primary duties related to dysphagia and mealtime, one part time SLP was primarily assigned to complete annual assessments and the other part time clinician (five to 10 hours weekly). Based on a review of documentation and interviews with therapy staff, the Department did not document appropriate qualifications for licensed SLPs and assistants (proof of current license) and/or continuing education in the last 12 months. A current license for Bahola Puentes-Polo, MS, CCC/SLP was submitted in response to the monitoring team's document request, but not for the other two SLPs currently providing services at EPSSLC (Henry Kielb, MA, CCC-SLP and Mary Mooney, MS, CCC/SLP). There were no CVs submitted for any SLPs regarding CVs for PNMT. It was documented, "has not changed since last visit," though there were two recently hired contract SLPs. Each of these staff were listed as PNMP Committee Meeting Participants, so it would be expected that CVs would have been submitted for them. There was evidence that Henry Kielb, MA, CCC/SLP had completed VitalStim certification in June 2009, but no continuing education was documented for any of the SLPs related to communication since the previous site visit in January 2010. There was a report of SLP attendance for webinars conducted by the state, though these appeared to be related to	Noncompliance

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		dysphagia rather than communication, and there was no evidence of attendance submitted with the document request materials. Of the 28 records reviewed, 83% identified language difficulties for individuals who were not receiving active speech treatment or participating in a speech program beyond the communication books and wall boards. Examples are provided below. • While Individual #41 was described as having significant deficits in communication skills and was provided with an assistive device, the clinician who completed her assessment dated 4/6/10 merely stated that she required hand over hand assistance to use her 4 key Tech Talker in the expressive language and AAC sections of the report, but did not comment further with regard to the appropriateness of this system for her. A binder was also identified as available for her to "attempt to express 'yes' and 'no' responses with assistance from staff." There was no evidence that the clinician observed her using these devices and did not report on the appropriateness of the icons included in the Tech Talker. Staff had described that she used her "pinkie" finger to access the "TV" icon when it was time for the novellas she enjoyed watching but this was not reported by the SLP. • Individual #178 was also reported to have communication skill deficits and had previously been provided a Hip Talker device. By report, in his speech evaluation dated 3/3/10, he did not show interest in high tech devices. Although it was stated in the assessment that the SLP was going to look into other kinds of devices, there was no recommendation for speech services and staff were only to use the standard communication book and wallboards with him. • Only three individuals from the sample reviewed were recommended for communication- related interventions and included Individual #88, Individual #161 and Individual #69, however, only Individual #161 was included on the list submitted for those receiving direct speech therapy. • Individual #69 was listed as receiving VitalStim therapy as of 6/16/10 only, though this was not mentioned in his recent assessment dated 6/4/10. There was no rationale described in his assessment to warrant this intervention to address swallowing. Direct speech therapy for Individual #161 involved participation in the Cognitive Linguistic and Writing groups provided by Henry Kielb, MA, CCC-SLP. Subsequently numerous others with severe deficits in communication abilities were not provided supports to address this. Further, there was no rationale provided for any of the three individuals recommended for communication-related intervention. In fact, these three individuals each were functional verbal communicators and were described with the highest level of	

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		communication skills of any of the 28 individuals for whom assessments were submitted. Clearly the department lacked an understanding of the priorities as outlined in the Settlement Agreement. **Standard: Communicative Aids and Speech Generated Devices (simple and complex) were provided to individuals based on need and not staff availability. All individuals in need of AAC, received AAC. SLPs actively participated in all facets of care in which communication is relevant.** By report of the SLPs interviewed, there were number of individuals who could benefit from communication supports beyond that of the current communication dictionaries and communication books provided to all individuals living at EPSSLC, but were not being provided these supports due to insufficient staffing. This was validated by the monitoring team. • There were at least 90 individuals (66% of current census of 137) identified as "non-verbal" or "minimal verbal" by the speech clinicians per assessments completed as included in the spreadsheet submitted. Though multiple undated spreadsheets were submitted, one listed evaluations for 2010, so it was concluded that this was the most current version by the monitoring team. • Only 18 of these individuals were recommended for communication aids or systems based on the most recent assessment including the following: talking photo album (14), Step Talker (1), Hip Talker (3), Go Talk 20 (2). • One of the Hip Talker devices, for Individual #39, was listed as discontinued in February 2010. • Only 19% of those who were identified as non-verbal or minimally verbal were recommended for augmentative or assistive systems for communication. • Other devices listed were more related to environmental control rather than communication and included a "control switch" for Individual #13 and Individual #16, a three band amplification device, as well as a Walkman with earphones for Individual #93. There were 19 individuals listed on an additional spreadsheet (Augmentative Device/Communication Book Monitoring 2009-2010 Spreadsheet) submitted as a list of individuals with at least one type of AAC device (high and low tech). This included the following: hearing aid (Individual #10), Hip Talker (Individual #63 and Individual #125), Step Talker (Individual #16), Go Talk 20 (Individual #92 and Individual #106), Talking Photo Album (Individual #11, Individual #21, Individual #58, Individual #1, Individual #183, Individual #105, Individual #71, Individual #113, Individual #114, Individual #29, Individual #41, Individual #189, and Individual #40), and 4 keypad Tech Talker (Individual #41). Individual #39 had been provided a Hip Talker, but this had been	

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		discontinued. These aids were in addition to the communication dictionary and book provided to each individual, including those that were identified as verbal. Of the 20 individuals provided AAC, 20% were considered to be verbal. Though the remaining 16 individuals were listed as non-verbal, another 74 individuals were non-verbal and did not have AAC supports outside of a communication dictionary and book. Individual #12 was listed as needing a Talking Photo Album but was not listed as having one. The Tech Talker provided to Individual #41 was not listed as recommended per her assessment dated 4/6/10 but rather a talking photo album only. There had been a correction in the monitoring database for Individual #92 to reflect that she used a Go Talk 20 rather than a Tech Talker 8 an error identified during the previous site visit by the monitoring team. This data reflected no net gain in the number of aids or systems available to the individuals living at EPSSLC since the previous onsite visit by the monitoring team. As stated in the baseline monitoring report, the clinician(s) had used many "canned" methods and strategies in order to manage their time and resources. Much of what was provided was not individualized based on skill level, potential, or need and, as a consequence, was often not meaningful or functional. This remained essentially unchanged at this time as well.	
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.	Screening and assessment procedures were not adequate to meet the requirements of this provision item. Further, based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement. **Standard: All individuals in need of AAC were identified as being in need of AAC.** The five most current assessments completed by each SLP was requested. There were nine assessments submitted completed by: Bahola Puentes Polo, MS, CCC-SLP • Individual #88 (6/14/10) • Individual #67 (6/2/10) • Individual #189 (6/2/10) • Individual #161 (5/14/10) Henry Kielb, MA, CCC-SLP • Individual #73 (6/2/10) • Individual #69 (6/4/10)	Noncompliance

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		• Individual #54 (6/2/10) • Individual #119 (6/1/10) • Individual #15 (6/12/10) There were no assessments submitted as completed by Mary Mooney, MS, CCC-SLP, as requested by the monitoring team. Additionally, SLP assessments were requested for 20 individuals as part of a record review by the monitoring team. All 20 were submitted with one duplicated by the request just previously described above for Individual #67. One of these was undated and the clinician completing the assessment was not identified (Individual #68). Approximately 45% of these additional assessments were completed since the baseline onsite review by the monitoring team (1/11/10 -1/15/10) and 30% since the baseline report dated 3/17/10. There was no discernible difference in the format, content or analysis of findings noted in the assessments completed since the previous review for those assessments completed by the full time clinician, Henry Kielb, MA, CCC-SLP who had been employed at EPSSLC at the time of the review. A more comprehensive and functional description of the individual's communication and language skills was noted in the assessments completed by the part-time contract clinician, Bahola Puentes-Polo, MS, CCC-SLP and, in general, the Augmentative and Alternate Communication section of the assessment was more complete and showed actual assessment of the current supports provided and trials for additional supports were clearly documented. There was no evidence of assessment related to this section in the assessments completed by Mr. Kielb which only offered a rote statement that staff should offer opportunities to use the generic communication book and wallboards. Eight of the 28 assessments described individuals as verbal. Only three of these individuals, however, presented with skills that were deemed to be functional or effective (Individual #88, Individual #69, and Individual #161). Others presented with less than functional verbal skills and included the following. • Individual #119 was described as "likely" understanding single content words and whispered several key content words such as "water," "baby," "soda," "shower," "coke," "mama," "bye bye," and "sorate" a word described by staff to mean "Ensure" or "chocolate." The clinician did not describe if these words were used appropriately in context. She used two signs ("drink" and "bathroom"), and in addition to gestures, physical contact and self-injurious behaviors to express her needs and feelings by report. She slapped herself and grabbed the clothing of others when frustrated or angry. • Individual #73 was described as responding to some verbal requests with accuracy. She used some phrases and words in Spanish to express "I'm hungry"	

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		and "I don't want that." Her yes/no responses were reported to be unreliable. She exhibited significant and extended crying episodes and emotional lability. She had regressed over the last year with evidence of increased "frustration-like communicative behaviors." There were no individualized communication recommendations other that directing staff to use the Augmentative Communication Picture Book and the Communication Wallboards. There was no evidence of collaboration with Psychology other than to "mention" that she had possibly sustained a head injury prior to her admission to EPSSLC secondary to reported history of abusive living conditions. Recommendations stated that "No Speech Therapy is needed at this time." • Individual #71 was described as responding to his name and establishing eye contact. He produced "a few words and phrases" by report, but these were not described by the clinician in his assessment dated 3/8/10. He was further described as turning his head away to designate refusal and used facial expressions nodding and body position to express other needs and feelings. This would not be descriptive of an individual with sufficiently functional and effective communication skills verbally or non-verbally, yet the only recommendation for Individual #71 was that staff were to use the standard communication book and wallboards as prescribed for most everyone else at EPSSLC. • Individual #178 was tested by the clinician and described to understand "kicking," dripping," "elbow," "sawing," "panda," dentist," and "tunnel." It was not clear what he functionally understood related to his daily routine and social conversation. He was described as producing "unintelligible" or "distorted" words. Further, it was stated that while he "produced a few words associated with toileting, common foods and animals; he showed a paucity (limited amount) of verbal communication." He also used pointing, gestures, eye contact, facial expressions, pouting, and smiling to augment his speech. His expressive language was disproportionately decreased relative to his receptive abilities, with approximately 50% of words used described as unintelligible. There was no Speech Therapy or AAC supports recommended other than the generic communication book and wallboards as prescribed for everyone else living at EPSSLC. • Individual #97 was described with the ability to produce a few basic words in his primary language, Spanish. He blew kisses to staff and yelled in anger. He closed his mouth and turned his head away when choosing not to cooperate with staff or structured activities. He was reported to require moderate to maximum verbal cues and hand over hand assistance to complete basic one part commands and to "comprehend" basic concepts including colors, shapes, emotions and object manipulation. He also was able to "comprehend" a few	

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		basic Spanish words and phrases. The only recommendation was the communication book and wall boards as prescribed for everyone else living at EPSSLC. Five of 28 assessments reviewed (56% of the assessments submitted) indicated that individuals identified with severe expressive/receptive language deficits did not have AAC investigated and assessed including Individual #73, Individual #54, Individual #119, Individual #15, Individual #189. None of these individuals was assessed for AAC. Recommendations were made to use the Augmentative Communication Picture Book and Communication Picture Wallboards, but there was no description of how these were used by the individual but merely provided standardized generic instructions for staff. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission or change in status.** Individuals who were newly admitted to the facility received the standard assessment within 30 days of admission. There was no indication that individuals were re-evaluated upon change in status. **Standard: Communication Assessment addresses:** • **Both verbal and nonverbal skills** • **Expansion of current abilities** • **Development of new skills** • **Whether the individual requires direct or indirect Speech Language services and** • **The need for further assessment in Augmentative Communication.** The majority of the assessments reviewed at EPSSLC addressed both verbal and nonverbal skills, though in a very limited manner. There was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish goals and objectives for communication supports and interventions. It was also not clear as to how effective the current methods used by each individual were within their daily routine. By report, new sections of the assessment format were added to more effectively identify "optimal" communication strategies for staff to implement. This was not evident in the assessments submitted, and per the POI, was implemented on 6/23/10, weeks just prior to the onsite review by the monitoring team. In 14 of 28 records reviewed, the assessment addressed expansion of current abilities,	

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		though generally only as it related to the following statement or one similar: Staff should work with the individual to "maintain or expand the current level of communication skills through daily purposeful interactions." It was suggested that Individual #21 continue with hand over hand assistance with her photo album, but there was no indication that the expectation was for expansion of her current communication skills. Individual #41 was to "continue with the use of the 4 Key Pad Tech-Talker" but with no recommendations to expand her current skills. Again this was inadequate to effectively establish goals for supports and interventions. In three of 28 records reviewed, the assessment minimally addressed development of new skills. Two assessments recommended Speech Therapy in the Speech Therapy Cognitive Linguistic Group (Individual #88 and Individual #161). Individual #161 was described as an effective communicator in her primary language, Spanish, and was able to carry on conversations with others appropriately. It was recommended that she expand her writing skills in the Speech Therapy Syntax Writing Group. The evaluation for Individual #88 was more comprehensive than the others and provided more specific suggestions for staff related to how they should interact with her across a variety of settings. No other individuals were recommended for speech interventions of any kind beyond that of the communication books and wall boards. Neither assessment clearly stated a rationale for why these interventions were indicated nor were specific outcomes or goals established. One other assessment, for Individual #69, recommended individual speech therapy to address language development and cognition but the evaluation did not establish a clear rationale for why this was indicated and did not identify any expected outcomes of this intervention. Only 3 of 28 records reviewed addressed whether the individual required direct or indirect Speech Language services. Two recommended group speech therapy and one identified a need for individual speech therapy. The other 26 assessments did not identify any communication supports beyond the use of the communication books and wall boards. None of the 28 records reviewed addressed the need for further assessment in Augmentative Communication. This area was severely deficient and as a result numerous individuals at EPSSLC were denied access to AAC systems to enhance and expand their communicative efforts. It was of great concern to the monitoring team that so little had been done in the last six months to address this area. While the POI continued to site the lack of staff, there was a significant lack of effort to address AAC with the existing resources. With the addition of contract staff over the summer, the focus appeared to be directed toward completion of annual assessments and a list of 12 individuals with sign language needs. The plan, however, was to review everyone else over the course of the next year. It was of concern that even recent assessments were	

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		limited as to assessment of AAC. In two cases the contract SLP made an effort to more comprehensively assess the potential for AAC use and to assess the effectiveness of the communication books provided to everyone (Individual #88 and Individual #4). These assessments were considered to be much more comprehensive than those provided by the fulltime SLP. Individual #4 was described as using non-verbal communication including facial expressions, vocalization, and visual fixation and environmental scanning with his eyes. In addition, he was "able to establish communicative intent by maintaining eye contact with others." In the case of Individual #4, however, switches were ruled out as a possibility due to "motor limitations" and unresponsiveness. It was noted in the OT/PT assessment that he moved his arms to cross midline and to reach up to his face, though his movement was "ataxic and spastic." He was also able to move his head and turned his head to locate sound. He was also observed to scratch his fingers on a Velcro strip. These each suggested possible modes of access to AAC that were not noted by the SLP. Had a comprehensive assessment of Individual #4's skills and potentials been conducted in collaboration with other team members such as OT and PT, a more appropriate assessment would have been provided to Individual #4. It was of concern to the monitoring team that the addition of "sections" to the assessment report would solve this problem and showed that the facility did not understand the process involved in the provision of communication supports that include AAC. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals.** Per the list submitted, there were nine individuals who participated in group therapy via the "Cognitive Linguistic" (Individual #161, Individual #14, Individual #37, Individual #90, Individual #120, and Individual #172) and/or "Writing Group" (Individual #161, Individual #112, Individual #79, Individual #42, and Individual #172). Though it was indicated in his assessment, Individual #69 was included on the list as receiving individual speech therapy "to address language development and cognition." All individuals living at EPSSLC received an annual Speech assessment whether they received speech services or not., however, no outcomes, goals or objectives were identified in the annual assessments for the three individuals recommended for group or individual speech therapy (Individual #69, Individual #161 or Individual #88). None of the others reviewed received any communication supports beyond the standard communication book and wallboards. **Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC.**	

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		Note: this may be included in the PBSP. By report, the assessment format had recently been revised with the intention of addressing behavioral issues that were related to communication, however, none of the 28 assessments submitted used this format, including at least nine assessments that had been completed in June 2010. The most recent of these for Individual #4, dated 6/21/10 was more comprehensive than earlier assessments, however, it did not have a section specifically related to behavioral issues as described by the clinicians. There was no evidence of maladaptive behaviors throughout the assessment report by Bahola Puentes-Polo. **Standard: Communication programs were integrated into the BSP as indicated.** There was no evidence of integration of communication programs into the PBSP. By report, a meeting was held with the Director of Behavioral Services on 6/22/10 to discuss integration of communication issues with behavioral assessments and the development of BSPs. In addition, a section was added to the Communications Skills Update entitled "Communication Strategies and the Behavioral Support Plan." This was implemented as recently as 6/23/10, weeks prior to the onsite review by the monitoring team, and none of the assessments reviewed incorporated this new format. While this is a step, it is far from actual integration of assessment, supports, and services to address communication deficits as they relate to behavioral concerns. **Standard: Policy existed that outlined assessment schedule and staff responsibilities.** The current state policy referenced a "Communication Master Plan" that was intended to prioritize assessments and services based on need. There did not appear to be a Master Plan in use at EPSSLC. The spreadsheets submitted indicated that assessments were completed for every individual on an annual basis according to the PSP schedule. There was no prioritization related to need for AAC. There were 140 individuals listed in the undated spreadsheet. Of these, only 76 were listed with a "last speech eval" though, by report, all individuals received an assessment every year. There were nine individuals listed with "next eval due" in 2011, but had not had a previous evaluation documented. The other individuals with "last speech eval" identified had assessments listed that were current within the last 12 months. One of the new contract speech language pathologists, Mary Mooney, had begun to complete assessments on individuals assigned to her. Many of these used or had a history of using sign language and this was an area of specialty for her. There had been no prioritization of individuals who had behavioral concerns for assessment related to	

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		communication and/or AAC systems. At the time of this review, the other contract SLP had been assigned to complete annual assessments, but it was unclear that she would be providing supports and services for those who would benefit from these. The plan at EPSSLC appeared to be to continue to evaluate everyone, but essentially nothing had changed with regard to other critical communication supports provided since the baseline review by the monitoring team. It was of concern to the monitoring team that per the POI, the SLPs anticipated an increase in referrals by the PST related to communication needs due to the emphasis of communication techniques and strategies in to the PST meetings. If the clinicians adequately provided comprehensive assessments prior to these meetings, particularly the annual meeting, communication issues should be appropriately addressed at that time rather than via a dependence on referrals. In other words, needs and supports should be anticipated by the communication experts and provided proactively rather than reactively upon referral by the PST.	
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.	Programming for communication was inadequate at EPSSLC and resulted in this provision item being rated as noncompliance. Further, based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement. **Standard: Rationales and descriptions of interventions regarding use and benefit from AAC were clearly integrated into the PSP.** There was no specific reference to AAC use in any of the PSPs reviewed. Descriptions of communication abilities were generally limited to the review of the Communication Dictionary and instructions for staff were rarely noted. • In the case of Individual #71, his most current assessment indicated that he produced a few words and phrases. Staff were advised to use visual and physical prompts so that he could understand communication during his daily routine. It was recommended that staff use his communication book and the picture wall boards to “maintain or expand his current level of communication skills through daily purposeful interactions.” This was the same statement noted in at least 11 of the 28 other assessments submitted and was not individualized for Individual #71. A Special Review Referral consult dated 11/19/09, indicated that “due to his ability to meet his goal and objective,” it was recommended that he should be discharged from Augmentative Communication Therapy. There was no statement of what the goals and objectives were and there was no description of his performance related to those to justify discharge from this service.	Noncompliance

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		Staff were instructed to provide a Talking Photo album from 10:30 to 11:30 AM and 3:00 to 4:00 Monday through Friday, and to provide hand over hand assistance to turn the pages and to press the play button for each page. He was to be restricted from using the device during his mealtime. There was no mention of this device in any way in his most current assessment dated 3/10/10. There was no mention of this anywhere in his PSP dated 3/11/10 other than in the review of PNMP section. His PSP indicated that he used body language, gestures, and a few words and phrases to communicate with others. His PSP described that he "will gain independence in his daily activities" and included training objectives for pushing a button to open an automatic door, hand money to a cashier, focus his attention, hold a bathing mitt, and to manipulate textured objects. His performance for grasp and release of objects was reported as 100% as of 9/13/09, however, there were no objectives related to improving his ability to make requests, choices, or otherwise express his wants and needs, though he clearly appeared to demonstrate need and potential for use of AAC. The assessment recommendations by the SLP were repeated in the Speech language Evaluation section of the PSP related to the communication picture book and wall boards. The communication book was also referenced in the PNMP review. There was a note to "please discuss due to conflicts with last physical" in the communication section of the PNMP, but there was no further documentation in the PSP in this regard so it was not clear what the conflict or concern was. A "proposed" PNMP was submitted for Individual #71, dated as revised 4/2/10, and again identified that Individual #71 continued to only have access to his Talking Photo Album two prescribed hours a day only. As identified in the baseline review by the monitoring team, this continued to be a concern in that assistive communication systems should not be prescriptive in nature but functional, meaningful and available to the individual throughout the day and across settings. • In the case of Individual #11, her most current assessment indicated that she used a few words in Spanish, used her head to convey refusal and to put objects down when she was finished with an activity or ambulate in her gait trainer toward others. Staff were advised to use her communication book to "facilitate interaction and communication" and to "maintain" her current level of communication skills through daily purposeful activities." This was the same statement noted in numerous other assessments submitted and was not individualized for Individual #11. A Special Review Referral consult dated 11/19/09, indicated that "due to her	

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		ability to meet this goal and objective," it was recommended that she should be discharged from Augmentative Communication Therapy. This was the same discharge statement on the same date as that for Individual #71 described above. As in the case of Individual #71, there was no statement of what the goals and objectives were and there was no description of her performance related to those to justify discharge from this service. The PNMP submitted for Individual #11, dated as revised 4/27/10, identified that she continued to only have access to her Talking Photo Album two prescribed hours a day only. As stated above, this continued to be a concern. **Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** As stated above, the PSP offered very limited descriptions of how a person communicated with others and even more limited instructions as to how staff would best communicate with them. The most descriptive information was included in the communication dictionary, but virtually no information related to AAC in the communication assessments or PSPs beyond the generic communication books. **Standard: AAC devices were portable and functional in a variety of settings.** As described above, the AAC systems were generally prescriptive in nature and appeared to be developed for staff use rather than that of the person for whom they were intended as in the case of the Talking Photo Albums. These were used only in the homes and at two scheduled times on Monday through Friday only. **Standard: AAC devices were individualized and meaningful to the individual.** As stated above, the communication books and the talking photo albums were not individualized and in most cases during the onsite review, the monitoring team did not observe these in use but rather laying on tables or opened in an individual's lap with no interaction occurring. • For example, in the case of Individual #41, she had a 4 picture icon system available to her, however the icons were limited to "milk," "musical instruments," "toothbrush and toothpaste," and "TV." Other than the television, it was unclear as to the meaningfulness of that particular group of icons. Staff reported that she used her "pinkie" finger to access the television icon at the time that novellas were on which she enjoyed watching. Staff indicated that she was not noted to use the other three. The idea that a "book" was the optimal communication method for everyone living at	

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		EPSSLC was of concern. The contract SLP had pointed out, in the case of one individual, that the icons were not of an appropriate size and Consider that one individual may require actual objects, such as a toothbrush to understand that it was time to brush his or her teeth rather than an icon of a toothbrush, while another person might require a photograph of his or her toothbrush to ensure understanding. One individual may be able to visually scan and differentiate the bathroom from a page full of icons while the next person may require that a large size photo of the actual place. An individual may be able to make a choice between two tangible objects while another may be able to do it by being shown two pictures. The communication book was the sole system for many individuals and though it was reported that the first pages were individualized to things of interest to them, the system itself did not incorporate each individual's needs and abilities to access it or capitalize on those things that were most important or meaningful to them, things that they were mostly likely to need or want. **Standard: Staff were trained in the use of the AAC.** Staff received general training related to communication in new employee orientation, but very limited staff training was provided by the speech staff following new employee orientation. The current POI indicated that basic communication methods and strategies to "optimize" communication were to be integrated into the PNMPs so that staff would be able to read these and incorporate them into the daily routine. Staff were expected to "actively look for opportunities to carryout communication strategies with no scheduled times." It was of concern that there was an expectation that staff would be able to carry out these strategies on their own and that there was no plan to provide staff training in this regard. This was noted throughout this onsite visit as staff had the communication books out in many instances but were not observed to use them to interact with the individuals to whom they were assigned. **Standard: Communication strategies/devices were implemented and used.** The communication books were noted, but as stated above they were not in use, but rather were seen sitting on tables or in individual's laps. Devices for Individual #41 and Individual #92 were observed in use during PNMP clinics, but not otherwise in the homes or dining areas. **Standard: General AAC devices were available in common areas.** There were a number of wallboards available in the homes and staff had previously received training with regard to their use as identified in the monitoring team's report in January 2010. There was no review of individual use in specific assessments though anecdotally, one clinician related a single story during both onsite review's about how	

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		one gentleman used the system on a specific occasion. Use of these systems was not observed during this onsite review. By report, a number of common devices were on order for use in the homes and workshops, but the assessments reviewed did not reflect a specific need for AAC devices.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	A monitoring system was not in place at EPSSLC as required by this provision. Further, based on interview and review of the POI submitted, the facility concurred that they were not in compliance with this provision of the Settlement Agreement. **Standard: Monitoring system was in place that: tracked the presence of ACC; working condition of AAC; the implementation of the system; and effectiveness of the system.** A review of monitoring documentation from August 2009 to June 2010 listed dates that staff were monitored relative to AAC. Specific findings were not recorded, but, by report, the monitoring was limited to the presence and working condition of the system. There was no review of implementation or effectiveness, even in the annual assessments conducted with the exception of a very few assessments completed for individuals in the last month by the new contract SLP. SLP technicians, rather than the professional staff, conducted this monitoring. The SLP technicians were asked about the process they used to monitor for AAC. They indicated that they looked for the device and when they found it, they added the date as the date monitored. As a result, the data gathered as result of monitoring did not reflect actual compliance with regard to the presence of AAC, but would always reflect 100% even when the AAC system was not found. There was no monitoring recorded for the month of February 2010 or July 2010 for any homes. It was noted in the spreadsheets submitted that there were numerous other blanks in the data for all homes with the exception of Cottage 513. It was unclear if the missing data reflected that monitoring was not conducted or that the AAC system was not located by the monitor. AAC systems were included in the PNMP monitoring conducted by the PNMP Coordinators as well as professional staff, but again the focus was only on the availability and working condition of the system rather than appropriate implementation and effectiveness. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** By report, monitoring of AAC was conducted only in the homes rather than across	Noncompliance

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		settings. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** There was no system of validation of monitors established at EPSSLC at the time of this onsite review by the monitoring team. There were no communication programs implemented by non-professional staff, so validation that a program was implemented as designed or that data was collected as intended was not indicated at this time.	

Recommendations:

1. Utilization of contract staff should be carefully considered. Delegation of only assessment responsibilities will result in a continued poverty of implementation of communication programs and AAC systems and retention of talented professionals will be difficult. The contract SLPs appeared to be dynamic and knowledgeable. Their talents should be put to smart use.

2. Work assignment of speech technicians should take into consideration that as more AAC systems are recommended, there will be a need to develop pictures and other materials for communication boards, books, etc.

3. It was positive that the SLPs were beginning to be present for the PNMP clinic assessments. This would be an excellent opportunity to gain valuable information related to not only communication abilities, but also to gain better understanding of the impact of position on movement and vision and to identify optimal access sites for AAC use. Problem-solving related to communication should not be an afterthought for the design and fabrication of seating systems but rather an integral part of the process. The SLPs must not be bystanders or observers but rather active participants for this process to result in positive outcomes.

4. Integration of communication strategies within the PSP should not be considered merely a written exercise as in adding a section to the SLP assessment or including written descriptions in the BSP and PSP documents (though those are a start), but rather integrated into the implementation of all the support strategies deemed to be best for each individual. Specific communication strategies to intervene and prevent escalation of target behaviors should be designed by the SLP, Psychology staff, and other team members. Staff training and monitoring should be a collaborative effort. Ways for an individual to ask for more materials in the work setting should also be collaboratively developed and trained. Communication opportunities should occur throughout the day, including mealtimes when, for some, they are most motivated to make a request or choice.

5. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans. Section R of the Supplemental POI indicated that the Program Developers had not received adequate training to explain the deficiencies in the instructional plans. While the Program Developers would likely benefit from additional training, the communication experts should serve to offer communication strategies appropriate to the context of the programs developed for individuals rather than leaving that responsibility to the Program Developers only. Similarly, consultation in work settings would also be critical to ensure integration in those environments as well.

6. The department should reconsider the priorities for supports and services based on need and all assessments must clearly establish a clear rationale to provide or to not provide communication supports.

7. The focus of monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the PNMP Coordinators.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Personal Support Plans (PSPs) for: • Individual #116, Individual #81, Individual #38, Individual #104, Individual #172, Individual #50, Individual #61, Individual #14, Individual #80, Individual #70, Individual #37, Individual #126, Individual #73, Individual #9, Individual #109, Individual #27, Individual #13, Individual #90, Individual #10, Individual #36, Individual #85, Individual #12, Individual #31, Individual #173, Individual #51 o Specific Program Objectives (SPOs) for: • Individual #61, Individual #172, Individual #14, Individual #70, Individual #37, Individual #80, Individual #36, Individual #85, Individual #12, Individual #51, Individual #99, Individual #23, Individual #31, Individual #73, Individual #90, Individual #13, Individual #27, Individual #9, Individual #109 o Qualified Mental Retardation Professionals (QMRP) Progress Notes for: • Individual #99, Individual #109, Individual #36, Individual #51, Individual #90, Individual #9, Individual #85, Individual #27, Individual #31, Individual #61, Individual #50, Individual #70 o Individual Education Plans for: • Individual #81, Individual #38, Individual #104 o Outline of Proposed Two Day Workshop entitled "Developing, Writing and Implementing Programs for Skill Acquisition" (undated) o Consumer Support Observation and Interview Form (undated) o List of school-aged individuals and the school each attended o PIT minutes, March 2010 and April 2010 Interviews and Meetings Held: o Valerie Grigg, Psychology department director o Gloria Loya, QMRP coordinator o Jan Chowning, Director of active treatment and day programs o Veronica Avita, Assistant director of programs o Three QMRPs who interacted regularly with the local public school district Observations Conducted: o Observations occurred in every day program and cottage at EPSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example:

	• Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training, etc.), and • Implementation of behavior support plans
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming at the facility regarding skill acquisition, engagement in activities, and staff training. To assess compliance with this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. Overall, the skill acquisition plans at EPSSLC were not adequate to promote growth, development, and independence. The facility needs to better document that individual skill acquisition plans are chosen to address individual needs and preference. Additionally, the methodology used to teach individual SPOs was found to be inadequate to maximize learning. The facility, however, had made several improvements since the baseline monitoring review. EPSSLC improved its review of specific training objectives (SPO) progress by adding graphed monthly summaries, and the facility scheduled a two day workshop to learn more about evidence-based techniques for teaching skills to individuals with developmental disabilities. The monitoring team was disappointed in the lack of progress noted in individual engagement. The level of individual engagement was low and approximately the same as that noted during the baseline monitoring review. Additionally, the individuals that were engaged were participating in the same routine activities (e.g., pegs in a board, puzzles, Legos) that they were involved in at the time of the baseline review. There was a new system for measuring individual engagement, and new schedules of interesting group activities posted in the cottages. Nevertheless, neither change was affecting the level or quality of engagement observed at the time of this onsite tour. For example, although schedules of activities were posted, they were not being implemented or followed. The facility needs to make a better effort to ensure that changes made result in meaningful changes in individual engagement. There was not much evidence of skill acquisition in the community. Only one individual was employed in the community at the time of the onsite tour, and there was no evidence that training in the community was developed to address individuals' needs for service or preferences.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of the skill acquisition programming, engagement of individuals in activities, and supports for educational services at EPSSLC. As indicated below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. As a result, this provision is rated as being in noncompliance. <u>Skill Acquisition Programming</u> Skill acquisition plans at EPSSLC consisted of: • Training objectives, referred to as specific program objectives (SPOs), that were written by four program developers, and monitored by the qualified mental retardation professionals (QMRP), and the QMRP coordinator. SPOs were implemented by direct care professionals (DCPs) • Medical desensitization programs written by the program developers and monitored by the QMRPs, and • Replacement behaviors were written by the psychology department. EPSSLC included replacement behaviors in each PBSP, as discussed in K4. There were, however, no descriptions of teaching conditions, no specific teaching instructions, and it was not clear how, or if, staff were trained to teach the replacement behaviors. Replacement behavior training procedures should be incorporated into the general training objective methodology, and conform to the standards of all skill acquisition programs listed below. Medical desensitization plans were written by the program developers at the time of the onsite tour, however, the psychology department was planning to begin to write and monitor them in the future. Further, the monitoring team found no skill acquisition programs targeting the enhancement or establishment of communication. It is recommended that the facility establish communication SPOs for individuals with communication needs. In addition, the facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written by the program developers and monitored by the QMRPs. The monitoring team did not review these plans. An important component of an effective skill acquisition plan is that it is based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, or psychological assessment. In other words, for skill	Noncompliance

#	Provision	Assessment of Status	Compliance
		acquisition plans, to be most useful in promoting individuals' growth, development, and independence, should be individualized, meaningful to the individual, and represent a documented need. Conversations with the QMRP coordinator indicated that the facility did attempt to incorporate preferences and needs in the development of each individual's SPOs. In reviewing 25 PSPs, however, it was not clear that SPOs were developed to address needs identified in each individual's assessments. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference. Once developed, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The SPOs at EPSSLC included some of these components. On the other hand, few of the SPOs reviewed included a complete and through task analysis of the learning objective. Additionally, the use of relevant discriminative stimuli or a plan for maintenance and generalization of achieved skills was not addressed in any of the plans reviewed. Additionally, although all of the SPOs reviewed indicated that individuals should be encouraged and praised, specific consequences for correct (e.g., positive reinforcers) or incorrect responding (e.g., three practice trials) were not consistently included in the plans. Finally, the training methodology for SPOs at EPSSLC was very general. For example, the training method for Individual #73's SPO to improve community awareness consisted of: 1. inform her she is working on community awareness,	

#	Provision	Assessment of Status	Compliance
		2. inform her she will be looking for three signs, 3. encourage her to identify the signs, and 4. give her praise for each sign she correctly identifies. There was no mention of prompting methods, or how to address refusal or incorrect responses. EPSSLC needs to expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. These methods include total-task chaining (i.e., the learner receives training on each step in the task analysis during every session), backward training (i.e., all the steps in the task analysis are initially completed by the trainer, except for the final behavior in the chain), and shaping. Overall, the SPOs reviewed did not promote growth, development, and independence. The monitoring team was encouraged, however, to learn that the facility had scheduled a two day workshop for the program developers and QMRPs to learn more about evidence-based techniques for teaching skills to individuals with developmental disabilities. The workshop was to include topics such as how to conduct a task analysis, error correction, chaining and shaping, and schedules of reinforcement. Engagement in Activities As a measure of the quality of individuals' lives at EPSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and cottages at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed below. The monitoring team was encouraged by the generally positive and caring interactions between staff and individuals at EPSSLC. It was also obvious that very few structured activities were implemented at the facility. Subsequently, the average engagement level across the facility was 42%, not substantially different from baseline measures of engagement (i.e., 36%). As can be seen in the table below, there was considerable variability across settings. An engagement level of 75% is a typical target in a facility like	

#	Provision	Assessment of Status	Compliance

EPSSLC, indicating that the engagement of the individuals at EPSSLC had considerable room to improve.

When individuals were engaged they were involved in individual activities such as placing pegs in a board, putting together puzzles, and interacting with Legos. Tours of each cottage revealed that there were schedules of interesting activities posted (e.g., a nature walk), however, the schedules were never adhered to in any of the cottages toured. The director of active treatment and day programming indicated that they only had staff to make the schedules, but not assist DCPs in implementing the activities. The facility needs to work on individualizing the activities scheduled, provide additional staff training, attempt some meaningful group activities, and actively manage individual engagement.

The facility initiated a methodology for capturing individual engagement, however it was not clear how often these data were collected and how, or if, they were used. For example, minutes from the facility's PIT meetings in March 2010 and April 2010 indicated that engagement data collected by the facility showed 87% and 70% engagement for each of the two months, respectively. It is unlikely that a standardized, reliable observational procedure was used.

It is recommended that the facility regularly collect engagement data, and establish specific engagement goals in each home and day program site and ensure that the collectors of the data know how to do so correctly. Of course, variability across sites is expected, based upon the type and number of individuals and staff in each setting. EPSSLC should incorporate this into the facility's QE Plan (see section E above).

Engagement Observations:

Location	Engaged	Staff-to-individual ratio
Cottage 506	3/9	5:9
Cottage 506	11/11	5:11
C Dorm	2/12	6:12
B Dorm	1/12	5:12
A Dorm	1/11	4:11
A Dorm	1/11	4:11
Cottage 507	0/2	4:2
Vocational Workshop	9/22	6:22
Vocational classrooms	4/5	4:5
Vocational classrooms	1/6	3:6
Cottage 508	4/8	3:4

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		(see continuation below)	

Vocational classrooms	1/8	6:8
Vocational classrooms	3/8	3:8
Vocational classrooms	2/8	4:8
Vocational Workshop	2 /28	7:28
Cottage 506	8/11	5:11
Cottage 506	9/12	5:12
Cottage 507	1/7	2:7
Cottage 507	2/7	2:7
Cottage 507	5/6	4:6
Cottage 512	3/5	3:5
Cottage 512	3/5	3:5
Cottage 513	4/5	2:5
Cottage 513	5/5	2:5
Cottage 508	3/8	2:8
Cottage 508	3/8	2:8
Cottage 509	3/3	1:3
Cottage 510	0/6	2:6
Cottage 511	1/2	1:2
Cottage 511	1/4	2:4
Cottage 510	1/5	1:5

Educational Services

Five individuals living at EPSSLC were under age 22 at the time of this onsite monitoring tour. These individuals qualified for special education services provided by the local education agency, the El Paso Independent School District. Two other individuals had graduated (i.e., based on their age of turning 22) within the month or so prior to the onsite monitoring tour. The monitoring team had the opportunity to review the Individual Education Plans for some of these individuals and also to meet with the three QMRPs who were responsible for working with the local school district.

The QMRPs described a very good working relationship with the local school district. For example, if an individual needed to miss school due to illness, the QMRP contact the school. More importantly, facility staff were able to attend meetings at the school and there were efforts to work towards consistent programming in both settings. Two examples are provided below.

- EPSSLC psychology staff created a visual schedule for one individual, based on the visual schedule he had at school. The facility's psychology staff and rights officer attended a meeting at the school regarding this programming (for Individual #81).

#	Provision	Assessment of Status	Compliance
		• One individual was working on a money coin identification program at school and it was replicated at the facility (for Individual # 69). Other efforts at collaborative work included having the QMRP attend the individual's annual IEP meeting at the school; and regular contact between the classroom teachers and the QMRPs via cell phones, email, and teacher visits to the facility. Recently, an aggressive outburst at school by one of the individuals led to EPSSLC offering to send a facility staff each day to provide additional one to one supervision and support to the individual so that he could remain in school. The QMRPs reported that the individuals were in segregated classrooms, but attended some activities integrated within the school building, such as physical education and music.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	As discussed above in S1, EPSSLC conducted annual assessments of preference, strengths, skills, and needs, but it did not appear that the information was used in any meaningful way to impact the type of instructional programming offered to the individual. It is suggested that the facility incorporate the results from multiple assessments and evaluations (i.e., in addition to the PALS) to choose individual skills to be trained. Additionally, while the PSP and PFW attempted to identify preferences, no evidence of systematic preference and reinforcement assessments were found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the	The monitoring team did not observe the implementation of SPOs in any of the day or residential cottages during the onsite tour, that is, no SPOs were implemented during the observation times conducted by the monitoring team. Several DCPs, however, were asked how they would implement the SPOs, and they were able to articulate the SPO, and generally describe the procedures to implement it.	Noncompliance

#	Provision	Assessment of Status	Compliance
	most integrated setting consistent with the individual's needs, and	Additionally, a sample of SPOs reviewed in five cottages (507, 512, 513, 508, and 509) revealed that acquisition plans had been conducted, and data collected, consistent with the specified schedule. Staff also indicated that they reinforced correct responses, but were unsure how to prompt and unsure of the role of practice in the training of individual skills. Generally, the skill acquisition plans appeared practical and functional, such as Individual #73's SPO for improving community awareness which was conducted while she was out on community outings. The QMRP coordinator recently began to graph SPO monthly data. Those data revealed that the plan was producing meaningful behavior change for some individuals (e.g., community awareness SPO for Individual #31), however, the plan did not appear to be producing meaningful change for others (e.g., bathing skills for Individual #109). The facility was clearly making progress on this provision. The monitoring team was encouraged that the facility recently began to graph SPO data. It is recommended that these data be used to make data-based decisions. For example, the SPO data revealed that some plans had extended absence of progress (e.g., Individual #109's bathing goal), but it was not clear whether these data prompted modifications in the plan or retraining of staff. Similarly several SPOs revealed that goals had seemingly been achieved months ago (e.g., toileting for Individual #109), but again it was not clear as to whether new goals were developed in response to her progress. Finally, the graphs revealed that some plans had missing data (e.g. dental desensitization for Individual #27), but no evidence that any action was taken to improve data collection. In future visits the monitoring team will be looking for graphed data for all individuals at EPSSLC, and evidence that these data produce data-based decisions that result in programmatic change.	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the onsite tour, one individual at EPSSLC worked in the community. This was the same number (and same individual) as observed during the baseline tour. The facility should strive to improve employment opportunities for individuals in the community. Many individuals at EPSSLC enjoyed various recreational activities in the community. It was not clear, however, if these community activities were developed to address specific individuals' needs for services or preference. Subsequent tours to EPSSLC will further evaluate the training individuals receive in the community in order to assess compliance with this provision item.	Noncompliance

Recommendations:

1. Establish communication SPOs for individuals with communication needs.

2. Replacement behaviors should include specific training procedures that are incorporated into the general SPO training methodology.

3. Ensure that all SPOs are based on needs/preferences documented in assessments.

4. Ensure that all skill acquisition plans (SPOs and replacement behaviors) contain the following components for learning and skill development:
    - A plan based on a task analysis
    - Behavioral objectives
    - Operational definitions of target behaviors
    - Description of teaching behaviors
    - Sufficient trials for learning to occur
    - Relevant discriminative stimuli
    - Specific instructions
    - Opportunity for the target behavior to occur
    - Specific consequences for correct response
    - Specific consequences for incorrect response
    - Plan for maintenance and generalization, and
    - Documentation methodology

5. Extend the training methodology for SPOs to procedures demonstrated to be effective in developing new behavioral repertoires.

6. The facility should regularly collect engagement data, and establish specific engagement goals in each home and day program site.

7. DCPs should be trained to increase meaningful group and individual engagement.

8. Develop a plan to track and increase levels of individual engagement in all settings.

9. Ensure that graphed data summaries of individual SPO progress are used to make data-based decisions.

10. Ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and six attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010 o EPSSLC POI and POI supplement, June 2010 o List of individuals referred for community placement, 6/17/10 o Post-move monitor's tracking sheet o List of individuals placed in the community during past six months o List of individuals for whom a CLDP existed o List of one individual (Individual #61) who had wanted placement in community: • PSP addendum note • Skill acquisition instructional programs o Identified obstacles to individual's movement for nine individuals o Training session for QMRPs on 3/25/10 about the entire community referral process, attendance sign in showed 10 staff attended o Job descriptions for APC and PMM o List of all trainings and educational opportunities provided to individuals, families, LARs, and staff o Tours of providers: nine pages, 1/5/10-6/23/10 o List of most recent CLOIP meetings for all individuals at EPSSLC o CLOIP worksheet for: • Individual #172, Individual #66, Individual #25, Individual #124, Individual #175, Individual #96, Individual #12, Individual #84, Individual #44, Individual #183 o LOD meeting monitoring checklist for PSP LOD for: • Individual #77 o PSPs for: • Individual #73, Individual #13, Individual #12, Individual #183, Individual #44, Individual #172, Individual #66, Individual #25, Individual #175, Individual #37, Individual #124, Individual #122, Individual #84, Individual #14, Individual #61, Individual #50, Individual #80, Individual #116, Individual #70, Individual #81, Individual #38, Individual #104, Individual #150, Individual #62, Individual #87 o CLDPs for: • Individual #62, Individual #87, Individual #150 o Draft CLDPs for: • Individual #124 o Post move monitoring checklists for:

	• Individual #62: 7 day and 45 day • Individual #87: 7 day, 45 day, and 90 day • Individual #150: 7 day <u>Interviews and Meetings Held</u>: o Olga Arciniega, Admissions and Placement Coordinator o Alice Villalobos, Post Move Monitor o Tony Ochoa, Facility Director o Ramona Gutierrez, MRA staff member who conducted CLOIPs o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o PSP Meeting for: • Individual #77 o CLDP Meeting for: • Individual #124 o Community group home visit, post-move monitoring for • Individual #150 o Community provider onsite presentation by Draco, Inc. o Many residences and day programs at EPSSLC
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: Overall, EPSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and as are detailed below in this section of the report. Further, the monitoring team learned that updates to the DADS policy and procedures for most integrated setting practices were forthcoming. Overall, very few individuals were in the referral process at EPSSLC. A new and creative way for community providers to educate individuals, staff, and families was begun recently, but an evaluation of its effectiveness was needed. Further, An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. EPSSLC had two staff who were dedicated to providing most integrated setting options to individuals. The Admissions and Placement Coordinator, and Post Move Monitor had many years of experience at EPSSLC.

	Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. The local area had a limited number of community residential providers, however, observation by the monitoring team and reports from facility staff indicated that the providers appeared committed to providing quality service. Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. Some of the discussions appeared to be brief and/or done in a rote manner, however, others appeared to be individualized and to begin to refer to optimistic visions for the individual. One PSP was observed (it was the only annual PSP scheduled during the week of the onsite monitoring visit). The LOD occurred towards the end of the two-hour meeting in a small, hot room. The discussion, not surprisingly, was relatively brief and contained little meaningful discussion among team members. More observations of PSP meetings will occur during the next onsite monitoring team visit. Based on this one observation, it is not possible to determine if the LODR in the written PSP represent a reliable description of the LOD tone, content, and outcome. The CLOIP was implemented for every individual reviewed. As indicated below, it should not be considered an assessment for placement, and further work will need to be done to create an assessment for each individual. Interestingly, comments on the CLOIP tool indicated that a number of individuals might be good candidates for community living, yet they were not referred for placement EPSSLC conducted a number of educational activities and participated in regular meetings with local MRAs. The facility recently initiated a self-advocacy group and now had the opportunity to add to the content of the self-advocacy groups and home meetings to include community placement, decision-making, and problem solving as regular topics for discussion. Modifications were recommended for improvements to the CLDP, the CLDP process, determination of essential and nonessential supports, and contents of the community placement report.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court	EPSSLC and the state engaged in activities to encourage and assist individuals to move to the most integrated setting. This provision item, however, cannot be considered to be in substantial compliance due to the need for further actions and activities to occur, including the implementation of revised policies, consideration of the opinions of professionals regarding appropriateness of community placement for each individual, and the monitoring and management of important referral-related outcome information.	Noncompliance

#	Provision	Assessment of Status	Compliance
	proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	EPSSLC activities in this area did not always appear to be consistent with the determinations of professionals that community placement was appropriate, and consistent with the individual's PSP. For example, according to the EPSSLC Admissions and Placement Coordinator, Individual #61 was the only individual living at EPSSLC who expressed a desire to live in the community. A review of a sample of 10 CLOIP worksheets and 25 annual PSP documents indicated that other individuals might also be determined appropriate for community placement by facility professionals, even if the individuals were not capable of expressing this preference themselves. For example, some of the individuals were noted to be possible good candidates for referral, but there was no indication of any action being taken to follow up on these professional opinions of PST members or CLOIP staff. EPSSLC management needs to be aware of these individuals. In order to do so, some sort of system to gather this information needs to be created that includes looking at the CLOIP worksheets and LOD records from the annual PSPs. EPSSLC activities to encourage and assist individuals to move to the most integrated setting were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the statutory authority of the state, and the needs of others with developmental disabilities. Even so, the number of individuals placed and the number of individuals on the active referral list were very small given the size of the facility and a review of the PSPs and CLOIP worksheets for many of the individuals who were not referred for placement. Three individuals had moved to the community during the past six months. One went to live with her family, and two had moved to local group homes. A referral list was presented to the monitoring team. It was dated 6/17/10 and contained seven names. By the time of the onsite monitoring tour, one of the individuals had been placed and the referrals of two other individuals were rescinded, leaving an active referral list of only four individuals. The status of these seven individuals is listed below: • Individual #124: provider was chosen, CLDP meeting occurred during the week of onsite monitoring tour, and a move date in September 2010 was scheduled • Individual #14: active referral, provider not yet chosen • Individual #183: active referral, provider not yet chosen • Individual #54: active referral, provider not yet chosen • Individual #150: placed, moved to home in the community in July 2010 • Individual #164: rescinded, due to parent request	

#	Provision	Assessment of Status	Compliance
		• Individual #188: rescinded, due to family inability to care for her at home The referral of a third individual, Individual #61, was also rescinded. Her name was not on the referral list because the referral had been rescinded. Apparently, the individual indicated a desire to move to the community, but during a Living Options Discussion at the annual PSP meeting, the individual indicated a change in preference and wanted to remain at EPSSLC and work on new programs regarding behavior control and safety skills. A review of these instructional programs indicated that the facility had plans in place to work with her on these skills (e.g., stranger safety, vocational skills, food preparation, bathing, making a daily spending budget, simple reading, night time toileting). The skill programs, however, were fraught with the methodological problems identified for all skill programs at EPSSLC and described in section S of this report. Olga Arciniega was the Admissions and Placement Coordinator (APC). She was assisted by Alice Villalobos. She was the facility's Post-Move Monitor (PMM) and also had other duties related to most integrated setting practices. The monitoring team had the opportunity to meet with both of these professionals. They were knowledgeable about the placement process and experienced with local providers and families. They described some upcoming changes to the state (and thereby facility) policies and practices regarding most integrated setting practices. Overall, funding did not appear to be an obstacle to any individual's transition. The APC reported that there were no instances of a placement being delayed or prevented due to lack of funding and that there were plenty of slots available to individuals at EPSSLC. She stated that she could see that limited funding for needed home renovations might present an obstacle in the future for the transition of some individuals (e.g., specialized bathtubs, widened hallways for wheelchairs). It appeared clear to the monitoring team that EPSSLC senior management did not receive regular reports and updates regarding the referral status of each individual (as well as all of the ongoing activities related to most integrated setting practices, including, for example, educational activities, community tours, rescinded referrals, and obstacles to placement). This should occur regularly if it is not already in place. One way to do so is to have referral information be part of the facility's quality assurance program that also included CAPs (but as noted above in section E of this report, EPSSLC did not have a comprehensive QA program).	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review,	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. This provision item was found to be in noncompliance due to upcoming changes in the state and facility policies regarding most integrated setting practices.	Noncompliance

#	Provision	Assessment of Status	Compliance
	revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily regarding methods of reporting facility information to the state central office. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included. The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. The APC reported that EPSSLC had adopted the state policy and was beginning to work under the policy, however, a number of revisions to policy and practice were in process and being updated. The revised policies were likely to include more involvement of the PST in the referral process and the post-referral process, PST involvement in visits to community providers, a review of post-move monitoring with the PST, and extra assurances and procedures regarding the determination of essential and nonessential supports in the CLDP. EPSSLC should determine whether any additional facility-specific policies would be of benefit to the facility's operations in this area. If so, the facility should obtain some type of documentation of approval of these policies from the DADS central office discipline head.	

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		The monitoring team also looked to see if the policies and procedures were being implemented consistently. EPSSLC staff were working towards implementing the DADS policy #018.1 and expected to modify facility practice based upon upcoming policy updates.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	This provision item was found to be in noncompliance based upon the need for implementation of a process to adequately identify the protections, services, and supports that need to be provided to the individual, as well as the identification of obstacles to movement to the most integrated setting and a plan to overcome those obstacles. The monitoring team was informed that new policies and procedures were being developed by DADS. These policies and procedures would be taught to QMRPs sometime over the next few months and then implemented at each facility. Twenty-five PSPs were reviewed for the individuals listed in the Documents Reviewed list at the beginning of this section of the report. All of these individuals resided at EPSSLC or had recently transitioned to community placements. The sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. One annual PSP meeting was observed. It was the only annual PSP meeting scheduled during the week of the onsite monitoring tour. <u>Protections, Services, and Supports</u> The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at EPSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion (LOD) section of the PSP. The PSP meeting, including the living options discussion (LOD) was led by the QMRP. The post-move monitor sat in on approximately eight PSP meetings per month, often taking notes and completing a checklist in order to monitor and provide feedback to the QMRP regarding the LOD section of the meeting. In addition, the APC reported that she occasionally met with the QMRPs to talk about ways to consider placement issues, actions plans, and obstacles during the LOD. Documentation regarding these meetings was not presented to the monitoring team. The comprehensiveness of the discussion reported in the Living Options Discussion Record (LODR) pages varied across these 25 PSPs. Overall, there was some	Noncompliance

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		individualization in the components of an optimistic vision for the individual's life in the community. Some examples were to live near a bus depot, have lots of shade trees, live near a fire station, have a home that was clutter free, be near family, have lots of windows, have a big high definition TV, live near a bowling alley, live near a fishing pond, and be able to do home cleaning activities, such loading and unloading the dishwasher. The LODRs indicated little discussion of obstacles to movement to the community. At most, the LODR contained one short paragraph regarding obstacles and it was not clear as to how any identified obstacles would or would not affect a referral for placement. Further, only one annual PSP meeting occurred during the week of the onsite monitoring tour. Therefore, only one LOD was observed and it was inadequate to meet the requirements of this provision item (see below). The living options discussion should include discussion about the ideal optimistic vision of the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance), and quality of life activities, such as leisure and recreation activities. Successfully facilitating this type of discussion will require additional specialized training of the person responsible. At EPSSLC, each PSP meeting was facilitated by QMRPs. They had many job responsibilities in addition to facilitating this discussion. The monitoring team, however, was informed that additional QMRPs were going to be hired and that this would reduce each QMRP's caseload to a more manageable size. Moreover, new QMRP training will occur in order for them to implement any new DADS policies in this area. At the PSP meeting for Individual #77, the living options discussion occurred at the end of the meeting. The meeting was held in a small, windowless, barely air-conditioned room. Seventeen people attended the meeting. This was more than typically attended PSP meetings, perhaps due in part to the monitoring team's observation, perhaps due in part to attendance by the individual's two sisters. The meeting was facilitated by the QMRP. She did a nice job throughout the meeting of trying to engage people in discussion while moving along the preplanned agenda. The meeting began with many PST members presenting assessment and assessment update information, followed by the QMRP presenting updates from those PST members who did not attend. This lasted for almost 90 minutes. Then the LOD began, that is, when everyone was tired, overheated, and not as engaged as they were when the meeting began. The monitoring team understands that eventually, the LOD will occur earlier in the meeting. The LOD began with the MRA CLOIP worker reporting on her CLOIP activities and	

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		sharing information with the individual's sisters. Then the sisters described the individual's previous failed experience with a community provider. In this case, she was not supervised, wandered from the group home, was lost, and was fortunately found by a family member. Nevertheless, the family appeared open to considering and learning about community options. Then each team member gave his or her opinion on community placement. Most recommended that she continue to live at EPSSLC for now. There was very little, if any, discussion among team members other than one point about whether it would be better for the individual to live in a small home with only one or two other individuals, or in a larger home where she would have more opportunities to socialize and be around others. Obstacles were not discussed explicitly, nor were any plans to overcome obstacles discussed. Overall, the LOD portion of the PSP meeting was rushed, and did not engage team members. It was a missed opportunity, especially given the attendance of two of the individual's sisters. Unfortunately, this was the only annual PSP meeting scheduled during the week of the onsite tour and, consequently, this was the sole observation of an LOD. Based on this one observation, it is not possible to determine if the LODR in the written PSPs of other individuals represented a reliable description of the LOD tone, content, and outcome. The monitoring team hopes that more PSP meeting LODs can be directly observed during the next onsite visit. At EPSSLC, the post move monitor observed many of the PSP meetings and monitored the performance of the PST regarding the living options discussion. The observation tool looked at these aspects of the living options discussion: • Efforts made to understand the individual's awareness of community options • Efforts made to determine the LAR's awareness of community options • Discussion of supports and services needed (in six areas, e.g. mobility) • Input from designated MRA • Inclusion of a vision statement • Determination of the most appropriate living arrangement • Development of action plans The completed tool for the above PSP LOD for Individual #77 was reviewed by the monitoring team. Ratings were not provided for each area. Instead, a narrative was written rather than an assessment that could provide useful feedback to the QMRP. More training is needed to help the PMM know how to use this as something other than a way of keeping notes of the content of the LOD. Further, the information gathered could be used by the facility's QE program.	

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		Obstacles to Movement There was no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility. Further, the facility did not maintain a record of the obstacles on an individual basis. The APC and the PMM reported that the PSTs were beginning to address the identification of obstacles and strategies to overcome them. A listing of obstacles for nine individuals was presented to the monitoring team and indicated an inadequate response to this provision item. This was a small sample (Individual #37, Individual #175, Individual #122, Individual #12, Individual #84, Individual #66, Individual #172, Individual #44, Individual #25). The provision requires that data and information be collected for all individuals at the facility. The results for this sample indicated that: • 1 individual expressed a preference to stay at EPSSLC • 3 had an LAR who's preference was for the individual to stay at EPSSLC; all 3 described having had failed community experiences previously • 3 individuals had behavioral issues • 1 individual was to begin exploring community options • 1 individual did not have legal status to allow for community placement Strategies to overcome these obstacles did not appear to be in place at EPSSLC. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary. In addition, the APC reported that the lack of opportunities for community employment presented an obstacle to placement for some individuals, especially those who were engaged in paid employment on the EPSSLC campus. This type of information should be incorporated into the facility's assessment of obstacles (see section T1g below).	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them	EPSSLC was engaged in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in, or was planning to engage in, each of the five activities listed in the DADS policy. Information provided to the monitoring team listed training and educational opportunities for individuals, families, and LARs.	Noncompliance

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	to make informed choices.	EPSSLC had made a lot of progress towards substantial compliance with this provision item, however, the item is rated as noncompliance due to the need for further activities to occur as indicated in some of the paragraphs below. First, EPSSLC had limited success with a fair for all providers. Instead, the APC came up with a creative idea of having one provider on campus at a time (there are only six community providers in the area), so that more in depth time could be spent with each provider. This was called the Day of Discovery and there was a schedule for the summer. Flyers and announcements were sent in English and Spanish to family members. During the onsite monitoring tour, a local provider Draco Services, set up a table and was available to staff, individuals, and family members. No family members had participated in any of these Day of Discovery events and there was no evaluation as to the effectiveness (i.e., positive outcomes) of this new presentation method. Second, an annual community living options inservice occurred in March 2010. It was run by the El Paso Community MHMR agency (the local MRA). Three families were reported to have attended and a number of questions were asked of the MRA staff. In addition, a training session was provided at EPSSLC for QMRPs about the entire community referral process (10 staff attended). Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was in place for all individuals. It was implemented by the CLOIP worker from the contracted MRA. A list of the most recent CLOIP meetings for all individuals at EPSSLC indicated that 70 individuals had gone through the process since January 2010. Of these 70 individuals, the LARs for 38 of them (28%) indicated that their preference was for the individual to live at EPSSLC and that no further CLOIP activities were to occur. In addition, the CLOIP worksheets were reviewed for 10 individuals (listed above in the Documents Reviewed section at the beginning of this section of the report). Overall, the CLOIP worksheets indicated that the MRA followed the process. The summary paragraphs indicated that, in the CLOIP worker's opinion based upon conducting the CLOIP, community placement appeared appropriate for many individuals and that many individuals appeared to be good candidates for living in the community. This information should be more explicitly incorporated into both the LOD and the facility's QE program (also see comments in sections T1a and T1b1 above). Fourth, the facility took individuals on visits to community providers. Since January 2010, 104 different individuals had gone on tours. This demonstrated good efforts by EPSSLC. Even so, some type of summary data or tracking database was needed to determine if all individuals who were supposed to have these opportunities were indeed	

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		presented with these opportunities, the number of times each individual went on a visit, the goal and outcome of the visit for each individual, and whether the visit was in line with the information in the living options discussion section of the PSP. Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work was needed to have these discussions be more comprehensive and meaningful. Of note was that no one with an LAR was on the EPSSLC referral list (i.e., none of the four active referrals). Moreover, one individual's referral was rescinded following parent/LAR rejection of the placement. Overall, LARs appeared to prefer service at EPSSLC (according to the MRA CLOIP worker and the facility's APC) to the exploration of community options, thus creating a challenge for EPSSLC to ensure that adequate education has occurred. Finally, although not solely related to education about community placements and providers, EPSSLC had recently initiated a self-advocacy group. This presents possible opportunities for education regarding community placement (also see section E above).	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. A process or tool for doing so did not exist at EPSSLC. The facility was awaiting guidance from DADS regarding this provision item. Consequently, it is rated as noncompliance. The CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement.	Noncompliance
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		

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	coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:		
	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 DADS policy on most integrated setting practices #018.1 provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CLDP in a timely manner. It also directed that a representative of the individual's PST submit a current assessment and/or discharge summary for inclusion in the CLDP. Overall, processes were in place at EPSSLC for this provision item. The limited number of cases (three CLDP documents, one CLDP meeting), combined with the upcoming revision to state policy, resulted in this provision item not being rated at this time. It is likely that this item will obtain substantial compliance following the policy update and implementation, and additional examples of EPSSLC's development and implementation of CLDPs. At EPSSLC, the CLDP was developed after a provider was chosen and a specific home was identified. This was typically only two to three weeks prior to the individual's move. Although activities had occurred prior to the CLDP meeting (e.g., referral, home visits, exchange of information), some of the CLDP topics might be better addressed, or at least initiated, much earlier to allow team members more time to participate and plan, especially, in regards to the development of lists of essential and nonessential supports. The CLDP activities were coordinated and managed by the APC. She gathered documents, put together a draft CLDP, and organized and ran the meeting. The monitoring team observed a CLDP meeting for Individual #124 during the week of the onsite monitoring tour. Sixteen people attended the meeting (also in the same small, hot room as was the annual PSP meeting described above), including the individual, although he was not able to communicate or participate in a meaningful way. The meeting was facilitated by the APC and was attended by numerous clinicians, direct support residential and day staff, and staff from the new provider agency. The individual's history was reviewed, essential and nonessential supports were discussed (see section T1e below), and an extensive discussion occurred around the best time and way for the individual to transition. The individual was stable behaviorally and medically. Therefore, extensive specialized supports did not need to be discussed. Recently, the CLDP was revised to include updates of assessments, completed by discipline department heads or therapists. Full assessments, records, and reports were still included in the overall referral packet, but the CLDP document itself now only	Not Rated

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		included updates. This was an improvement over the previous system that often included lengthy and somewhat outdated information that was not helpful to the CLDP process. Three CLDPs were reviewed for the individuals listed under the "Documents Reviewed" list at the beginning of this section of the report. These were all of the CLDPs at EPSSLC.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and facility director had responsibility and had agreed to the contents of the CLDP. Each CLDP also referred to a specific date for moving to the new placement. Specific timeframes regarding essential and nonessential supports are discussed below in section T1e.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Signatures indicated that guardians or LARs (when any existed or were appointed) were informed of the CLDP and participated in the process. A signature of the individual was on one of the CLDPs (the other two individuals were not capable of signing the CLDP).	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	As per the DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. In order for this item to be in substantial compliance, however, some sort of checklist or tracking tool needs to be used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so that PSTs and community providers can be assured that no relevant assessments are missing. The assessment documents for the three individuals for whom CLDPs were developed were reviewed in detail. Although numerous assessments were included, it was not possible for the monitoring team to determine if these assessments represented the full set of assessments relevant for the individual, however, they appeared to be comprehensive and relevant. The APC reported that she knew which assessments were required and that discharge summaries were also required for all disciplines (this was a new requirement). That is, even if an assessment had been done within the past year, an updated summary was	Noncompliance

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		required, too.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	It was the understanding of the monitoring team that upcoming changes in the policy on most integrated setting practices would include a focus on improving the process of identifying and following up on essential and nonessential supports. A review of the updated policy and procedure, and its implementation at EPSSLC will be required before this provision item can be considered to be in substantial compliance. A key part of the community placement process was the identification of essential and nonessential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Nonessential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all non-essential supports needed to be in place and addressed. Nonessential did not mean not needed. The MRA was responsible for ensuring that all essential supports were in place prior to the day of the individual's move. This responsibility was to soon become the facility's. This is likely to be more beneficial for the individual and for the transition process because of the facility's extensive knowledge about the individual, and because the facility will continue to be responsible for the post move monitoring of these supports. Each of the three EPSSLC CLDPs had a table that listed out essential and non-essential supports. Specific staff at EPSSLC and at the provider agency, however, were not identified by name. They should be. The table included target dates for putting these supports in place. The table listed 10 areas of supports (e.g., residential, vocational, safety). These pages were completed similarly, but not identically, across all CLDPs. Some of the supports were the same in every CLDP (e.g., transportation) and some referred to bureaucratic processes (e.g., site review by MRA, trust fund money forwarded). Even so, there was some individualization in these three lists of supports. Some of this individualization was in reference to personal preferences of the individuals. Other individualization was related to medical needs and staff training. This was also evidenced in the discussion observed by the monitoring team during the CLDP meeting for Individual #124. Nevertheless, EPSSLC should take steps to ensure that the list of essential and nonessential supports is comprehensive, clear, and complete. This is especially important because the essential and nonessential supports section of the CLDP provides	Noncompliance

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		the facility with its one chance to ensure that certain aspects of support will be provided to the individual. If an important support is left out this listing, the facility has no way of following up on it and requiring the provider to put the support in place. Therefore, this component of the CLDP is very critical to the ongoing success of each individual's placement. This will require a thorough reading of all assessments and assessment updates in addition to the current procedure of developing the list from CLDP meeting participants' discussion during the CLDP meeting. For instance, the monitoring team noted some items that might have been, but were not, included in the CLDP for Individual #62 were counseling, a structured schedule and routine, and specific attention to her osteoporosis. The four individuals involved in the CLDP process at EPSSLC had unique and varying needs, however, none presented with extremely complicated clinical, psychiatric, or behavioral challenges or histories. The monitoring team looks forward to observing the facility's ability to determine essential and nonessential supports to individuals with more challenging needs, too, as those individuals are referred for placement. In addition, some supports were written in a way that made them difficult, if not impossible, to measure or observe. As a consequence, the ability of the post move monitor to objectively determine their presence or absence became similarly difficult and certainly unreliable (also see section T2a of this report). Some examples are listed below. • Suitable transportation • Work on writing skills • Socialize with friends • Communication book Improvements to this portion of the CLDP process might include a more detailed listing of essential and non-essential supports during the living options discussion at the PSP meeting for those individuals who have been, or are likely to be, referred for placement. It is expected that the CLDP process will be modified at EPSSLC to: • ensure that all needs identified in the individual's current assessment are indicated as essential or non-essential supports, • define each of these essential and non-essential supports in more detail, and • specify the support in a manner that can be measured or verified.	
T1f	Each Facility shall develop and implement quality assurance	There was no quality assurance process in place at EPSSLC regarding this section T of the Settlement Agreement.	Noncompliance

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	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.	Moreover, the data collected by the post-move monitor was sent to DADS central office and not used at the facility level (although it was unclear as to what data were sent; the example given to the monitoring team did not indicate any ratings, as noted above).	
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.	EPSSLC was not in compliance with this provision item. EPSSLC was not gathering and analyzing information related to identified obstacles to individuals' movement to more integrated settings. Please also see the discussion in section T1b1 above. EPSSLC did not have a facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. At the time of the onsite monitoring visit and subsequent preparation of this report, DADS was in the process of developing an assessment and report to meet the requirements of this provision item. The monitoring team appreciated having had the opportunity to review a draft of this document and provide suggestions to DADS.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a	A community placement report was not issued to the monitoring team. Instead a state-generated document that included names of individuals from other facilities was submitted. Although not required by this provision item, the monitoring team recommends that the	Noncompliance

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	Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	facility's placement report also include a listing of individuals whose PSTs indicated would be good candidates for placement, but were not referred, as well as individuals who themselves expressed a desire to move to the community, but were not referred (though there appeared to be no examples of the latter at EPSSLC).	
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	This provision item was in substantial compliance. EPSSLC was implementing the post-move monitoring process, including the recent appointment of the post-move monitor. The post-move monitor was knowledgeable about many of the individuals, the local providers, and the CLOIP process. Visits occurred regularly and reports were completed thoroughly. Evidence was provided (either documents or written description by post-move monitor) for the presence of essential and nonessential supports. The post-move monitor maintained a schedule of post-move monitoring visits. This was	Substantial Compliance

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	individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	a very short list; at the time of the onsite monitoring tour, the post-move monitor was following only two individuals: Individual #150 and an individual from another facility who was placed in the El Paso area. The set of three post-move monitoring visits had been completed within the past few months for two other individuals: Individual #87 and Individual #62. Completed post move monitoring checklists were reviewed for the three individuals listed under Documents Reviewed in the Steps Taken section at the beginning of the report on this provision T. Overall, the reports indicated that essential and nonessential supports were in place or there was a plan for them to be put in place. All post move monitoring was done within the required timelines. Two aspects of the post-move monitoring at EPSSLC deserve mention because they demonstrated the thoroughness of the post-move monitor's actions. • Each post-move monitoring visit included a site visit to both the residence and the day program of the individual. • Detailed notes were made in the post-move monitoring tool that provided the reader with a lot of information about the status of the individual's transition. • Additional documents were attached to the completed tool to provide evidence of staff training, appointments, and so forth. There were no individuals who had returned to EPSSLC after placement. The monitoring team recommends that the post move monitor have the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. An additional recommendation is that the CLDP should specify the way the post-move monitor should determine the presence or absence of each essential and non-essential support. For example, the presence of the support was often determined based upon staff or individual report rather than on any type of documentation (e.g., 24 hour staff). For another example, transportation may have been considered present if a van was at the home rather than a determination as to whether the individual had access to activities that required transportation, or whether the van was available for individualized activities. The CLDP should be modified to include the type of evidence so that the post-move monitor knows how to assess its presence or absence, and the post-move monitoring form should be modified to specify whether this evidence was found.	
T2b	The Monitor may review the accuracy of the Facility's	As noted above in section T2a, post-move monitoring visits were occurring at EPSSLC. This item cannot be rated as in substantial compliance, however, until the monitoring	Not rated

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	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.	team has had the opportunity to observe an actual post-move monitoring visit. The monitoring team hopes that the facility will be able to schedule a post-move monitoring visit during the next onsite monitoring tour. Nevertheless, the monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of an individual, Individual #150, who had moved to the community within the previous two weeks. The 7-day had already been completed, therefore, this was not an official post-move monitoring visit. The monitoring team thanks the post-move monitor and the community agency for making arrangements for this visit to occur and for talking with the monitoring team about the individual's transition. The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and non-essential supports. The home was operated by Draco Services, Inc. The individual lived with one other individual and there was an expectation that one or two others would move in at some point in the near future. Individual #150 was seated in the living room during the visit to her home. She was nonverbal and required around the clock supervision. She appeared to be happy and content at this time. Her home staff reported that she hadn't had any problems and seemed to be adjusting well. She spent a lot of her time in the living room and central areas of the home. This was reported to be different than when she lived at EPSSLC where she spent a lot of her time in her bedroom. The home was in a very nice neighborhood and was beautifully furnished.	
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-	There were no individuals at EPSSLC to whom this provision item applied.	

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

Recommendations:

1. Implement updated policies and procedures when they are disseminated.

2. Consider whether to develop any facility-specific policies and procedures related to this provision of the Settlement Agreement. If any are developed, ensure the facility policies are in line with state policies, and obtain documentation from state office regarding the approval of state policies that add to, or supplement, state policies.

3. Ensure that the opinions of professionals (i.e., PST members) are considered when determining most integrated settings.

4. Collect information regarding those individuals for whom the PST believes community placement might be appropriate. For example, thoroughly review the CLOIP worksheets and the PSP LOD record. This information should be used by EPSSLC management, and by the APC.

5. Ensure that senior management at EPSSLC is regularly informed of the status of referrals, move dates, CLDPs, rescinded referrals, and other actions of the APC and the admissions and placement department.

6. Develop a quality assurance process for this provision. Ensure that relevant information is submitted and monitored by the QE department. Ensure that quality assurance processes are applied for all of section T, including but not limited to T1g.

7. Review and modify how the living options discussion occurs at the PSP meeting regarding the optimistic vision for the individual's placement in the community. Move LOD to the beginning of the meeting. Ensure that the LOD is thorough and meaningful.

8. Address the identified obstacles to individuals' movement to the most integrated setting:
    a. within the PSP meeting for each individual,
    b. across the facility by conducting a comprehensive assessment, and
    c. by developing action steps from DADS.

9. Continue to work on education of individuals and LARs regarding most integrated setting practices.
    a. Track the individuals who go on specific tours to ensure that the tour is an appropriate one given the needs of each individual.
    b. Examine the effects of the Day of Discovery sessions, and the MRA sessions, including, but not limited to the effect on LAR involvement in the referral process.

10. In the self-advocacy meetings, include discussion regarding choices, decision-making, and problem solving related to, at a minimum, rights and community placement. Consider doing the same, or similar, at home meetings.

11. Include the names of facility and provider staff in the section of the CLDP that identifies tasks and the responsible person.

12. Improve the way important essential and non-essential supports are included in the CLDP:
    a. Consider ways to begin developing the list of supports prior to the CLDP meeting.
    b. Ensure all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
        i. define each support in observable and measureable terms.
        ii. define the manner in which the presence of each support will be verified.
    c. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.

13. Create an assessment for placement as required by this provision.

14. Utilize the data collected by the APC and the post move monitor regarding (a) CLDP and transition process and (b) the living options discussion of the PSP meetings. For example, these data might be incorporated into the facility's QE program, and/or used by the APC to make decisions regarding the operation of her department.

15. Revise the post-move monitoring checklist to include detail regarding (a) how the presence or absence of supports was assessed, and (b) follow up activities for both essential and non-essential supports.

16. Provide opportunities for the post-move monitor to network with other post-move monitors at other facilities.

17. Consider adding additional information to the Community Placement Report as noted above in section T1h.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS DRAFT Policy: Consent-Guardianship #019 dated 1/15/10 o Determination for Need for Guardian Priority Tool completed for six individuals o List of Individuals whom LAR obtained since 1/12/09 o Priority Listing for Adults without guardians o DADS 2009 "Your Rights in a State Supported Living Center" Booklet o PSPs for: • Individual #12, Individual #23, Individual #183, Individual #84, Individual #66, Individual #96, Individual #124, Individual #2, Individual #110, and Individual #31, Individual #36, Individual #92, Individual #90 Interviews and Meetings Held: o Olga Arciniega, Director of Admissions and Family Relations Observations Conducted: o Human Rights Committee meeting 7/21/10 o PST meeting for Individual #77
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: The state policy addressing guardianship was in draft format in January 2010. The facility had not developed a policy regarding guardianship. The facility had just begun to address this provision at the time of the monitoring visit.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision	The state had developed a draft policy entitled "Consent and Guardianship" (Policy #019 dated 1/15/10) to address this provision of the Settlement Agreement. The draft state policy mandated that the facility appoint a Guardianship Coordinator who will maintain and update, semiannually, a list and prioritization of individuals who lack both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision.	Noncompliance

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	regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The draft policy also mandated that the Guardianship Coordinator would create a guardianship committee to determine which individuals on the list have the greatest prioritized need based on factors listed in the policy. These factors for determining priority need were in line with requirements of the Settlement Agreement. The Director of Admissions and Family Relations at the facility was assigned responsibility for dealing with guardianship issues. The facility had not yet developed a guardianship committee. QMRPs had begun to identify individuals who lacked both the functional capacity to render a decision and an appointed guardian. At the time of the monitoring visit, all individuals residing at EPSSLC had been assigned a priority level of one, two, or three. Twenty-one individuals had been identified as Priority I and five were identified as Priority II. Priority rating was determined by criteria on the Determination for Need of Guardian/Priority Tool. Thirteen PSPs were reviewed for guardianship/advocacy discussion. There were some discrepancies noted between information on the Priority for Guardianship List and PSPs reviewed. Six out of a sample of 13 individuals (46%) reviewed did not have information in the PSP that was consistent with the Priority List. • Individual #12 was considered a Priority I with no guardian or advocate according to the list. Her PSP indicated that her mother was not interested in becoming her guardian, but would serve as an advocate for her. • Individual #23 was considered a Priority I with no guardian or advocate according to the list. His PSP indicated that his parents were his advocates. • Individual #183 was considered a Priority I with no guardian or advocate according to the list. Her PSP indicated that she had an advocate. • Individual #96 was listed as Priority III. Her PSP indicated that she did not have an LAR, but that family members advocated for her. The team determined that she was unable to give informed consent for medical, programmatic, restrictive/intrusive practices, media/photo and release of records. There was no discussion around pursuing guardianship in her PSP. • Individual #90 was listed as Priority I with no guardian or advocate. His PSP indicated that he had an advocate. • Individual #92 was listed as Priority I with no guardian or advocate. Her PSP indicated that her father was an advocate for her. There was no discussion regarding guardianship in her PSP. The facility should continue to identify individuals who need an LAR and begin pursuing	

#	Provision	Assessment of Status	Compliance
		guardianship for those individuals according to assigned priority.	
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 state policy addressed efforts that should be made to obtain LARs for individuals when the PST has determined there is a need for a LAR. The Guardianship Coordinator reported that letters regarding guardianship had been sent to families and one nonprofit guardianship agency in the area had been identified as a possible resource for obtaining guardianship for priority I individuals. Since 1/1/10, guardians had been obtained for four individuals at the facility. This provision will be further reviewed during upcoming monitoring visits.	Noncompliance

Recommendations:

1. Continue to develop a list of LAR providers in the area.

2. Provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.

3. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o Completed record audits done by Priscilla Munoz and Priscilla Guevara, May and June 2010 o List of EPSSLC monthly sample of 10 individuals that indicated the five chosen for record audits o Table of contents for Avatar Clinician Workstation, 8/12/04 o EPSSLC listing of shared folders and folder owners o Active records of many individuals who lived at residences Dorm A, B, C, and Cottage 506 o Review of active records and individual notebooks of: • Individual #56, Individual #58, Individual #125 <u>Interviews and Meetings Held</u>: o Priscilla Munoz, Director of Medical Records o Priscilla Guevara, Unified Records Coordinator o Victor Quiroz, Data Analyst, QE Department <u>Observations Conducted</u>: o Records storage areas in residences o Records storage areas in administration buildings
	Facility Self-Assessment: Please see the Executive Summary section of this report.
	Summary of Monitor's Assessment: EPSSLC made progress towards meeting this provision of the Settlement Agreement. The new policy and record keeping practices were implemented in four of the 11 homes, representing approximately 43% of the individuals at the facility. The new records consisted of a multi-volume active record, an individual notebook, a master record of historical and legal documents, and an overflow record of thinned and purged materials that were stored for future use if needed. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. A master record existed and some sort of checklist of required/typical documents was needed to help ensure consistency across individuals. The Director of Medical Records and the Unified Records Coordinator were both committed to having an organized, user-friendly record keeping system. They were knowledgeable about the records and were

	interested in improving the records as implementation of this new system moved forward. EPSSLC should ensure that record keeping is tied into the facility's quality enhancement program and that quality assurance activities occur related to record keeping. Moreover, it will be important for EPSSLC to obtain feedback and suggestions from those who use the records regularly in order to make relevant and useful changes to the record keeping system. Management of the individual notebooks may become a challenge, especially regarding whether the size of the notebooks competes with the goal of having information readily available to direct support professionals. The monitoring team looks forward to EPSSLC's implementation of the new record keeping policy and practices.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	EPSSLC made progress in this area and established a unified record according to DADS policy for some, but not all of the individuals. Therefore, the rating for this provision item is noncompliance. DADS developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. EPSSLC adopted this policy in whole and did not have any facility-specific policies. If the facility management decides to create any additional policy or procedures, they should ensure that the contents are in line with the DADS policy and, further, approval from DADS central office should be obtained. The monitoring team looked to see if EPSSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. At the time of the onsite tour, EPSSLC had converted the records in four of the 11 homes (Dorms A, B, and C, and Cottage 506). The records were converted for approximately 43% of the individuals at the facility to the new system that consisted of • Active record • Individual notebook • Master record • Overflow files The facility's records activities were overseen by Priscilla Munoz with the assistance of Priscilla Guevara and an administrative clerk. Priscilla Guevara was the Unified Records Coordinator. Their responsibilities also included thinning of the records, and storage of	Noncompliance

#	Provision	Assessment of Status	Compliance
		the records. It appeared that these three staff should be able to manage the records according to the new policy. <u>Active records</u> The new active records varied in size based upon the amount of information in the individual's record. Most records contained three three-inch binders. Some contained only two binders, and others contained four binders. The active records were divided across the binders in the same way for all individuals. The active records were constructed following the order of sections from the state's table of contents. The integrated progress notes and physicians orders were together in the records, and for individuals with four binders, these two sections comprised the third binder, making it relatively easy for clinicians to access this information and to make entries. In the opinion of the record keeping staff, the active records were neater, more organized, and information was easier to find. They reported that the new plastic tabs were sturdier than what they had been using. The monitoring team looked at more than a dozen of these new records in the three Dorms and in home 506. Three records were reviewed in some detail and appeared to be representative of the full set of records that had been converted to the new system (Individual #56, Individual #58, Individual #125). Some positive actions taken by the record keeping staff are noted below: • Active records were in a new cabinet, easily accessible to staff • Active records were clearly labeled with the individual's name • Record keeping staff were responsive to a request from the nursing department to add additional tabs within the nursing section to make the records more manageable for them • Each record contained a checkout log for staff to sign <u>Individual notebooks</u> Individual notebooks were in place as per the state's policy. The individual records reviewed by the monitoring team appeared to contain everything required by the state's table of contents. This, however, led to the notebooks being very full (nearly exceeding the capacity of the one-inch binders) and thereby heavier and more cumbersome than the planners of this system likely anticipated. The purpose of the individual notebooks was to ensure that all relevant information was at hand for direct support professionals. EPSSLC will need to ensure that this is the case, that is, that the notebooks serve their intended purpose. This may require obtaining	

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		regular feedback and suggestions from direct support professionals and management staff at the homes and day programs. For example, the individual notebooks contained each individual's expressive language communication system of numerous pages of icon figures (i.e., his or her communication book). This may make it more difficult for individuals to use their personal communication systems. Further, the notebooks were required to be with the individual at all times. This created some challenges that EPSSLC will need to address as implementation moves forward. At the time of the onsite monitoring visit, the record keeping staff described a proposal to have backpacks and large purses available for individuals to carry their own notebooks. The monitoring team was concerned as to whether this might be counter-therapeutic for some individuals; whether it would create a negative stigmatizing effect, especially during community outings; and whether it was indeed the responsibility of the individual to keep and carry his or her own notebook. Master records A master record was kept for each individual. Some of the items in the master record were used regularly by some of the departments at EPSSLC, such as psychology. The record keeping staff made sure that documents were available as needed. EPSSLC's system would benefit from having some type of checklist that listed the documents that should be in each individual's master record. This can help the contents to be consistent across individuals. Overflow files Documents taken from each individual's records were stored and managed by the record keeping staff according to the record thinning schedule provided by the state.	
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.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy. DADS maintained a spreadsheet indicating the status of policies, protocols, and procedures for each provision in Part II of the Settlement Agreement (i.e., sections C through V).	Noncompliance
V3	Commencing within six months of	A quality assurance and quality enhancement procedure to ensure a unified record was	Noncompliance

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	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.	not in place. EPSSLC's quality enhancement department needs to be involved in addressing this provision item. Even so, the record keeping staff conducted four to five audits of individual records in both May and June 2010. The audits were based upon the monitoring team's checklist for this provision of the Settlement Agreement. The monitoring team was pleased to see that these activities were occurring. The facility, however, needs to ensure that the record audits done by the record keeping staff (or by whomever is assigned to do so by the facility) are assessing what the facility deems to be important to the record. For example, the facility will want to ensure that the audit looks at whether documents that are supposed to be in each section are indeed in each section. Numerous EPSSLC staff have record-related responsibilities (e.g., program developers put in the monthly data sheets) and it is possible for documents to be placed in the incorrect section of the record. In addition, EPSSLC should get feedback and suggestions from staff who use the records. This information can be used to improve the record keeping system and components. Implementation of the new record keeping system had only occurred a few months prior to the onsite monitoring visit. Once staff have used the system, useful feedback can be obtained from clinicians, managers, and direct support professionals. This will be especially important for the ongoing usage of the individual notebooks.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The facility did not have a means to assess this provision item. Monitoring team members in all disciplines found that the facility did not make data based decisions. For example, the QMRPs did not routinely utilize the records to identify SPO goals (see S1), and the psychologists did not routinely use individual records to make PBSP decisions (see K4 and K9). Although nursing recordkeeping practices were improved from the baseline review, forms for tracking health status information, such as neurological checks, intake/output, and seizures continued to be disorganized, incomplete, and inconsistently referenced as reviewed by clinical professionals. During the observation of psychiatry clinic, the nursing case manager provided the psychiatrist with historical data verbally, that is, with no written notes. Only one of the three clinicians was observed to even look at the record. Additionally, data, an essential element in the decision-making process regarding psychopharmacology, were not presented in an organized fashion. Observations of facility staff revealed that rather than relying on data or records, they utilized oral history or memory regarding an individual's	Noncompliance

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		behavioral challenges or response to specific strategies or interventions. In addition to the concerns noted above regarding the presentation of data, there was also no evidence of the use of objective rating scales to determine the presence or absence of symptoms of psychiatric disorders or to indicate the individual's response to a targeted intervention.	

Recommendations:

1. Complete the conversion of all individual records to the new system.
2. Assess individual notebooks to ensure they are being used as intended, that their size is not too large for the notebooks to be useful, and the manner in which responsibility for carrying the notebooks is assigned.
3. Ensure communication books are accessible to individuals and that their inclusion in the individual notebooks does not hinder an individual's ability to communicate.
4. Develop a checklist for the contents of the master record.
5. Complete the development of policies as described in provision item V2.
6. Incorporate record keeping activities into the facility's quality enhancement program.
7. Obtain feedback and suggestions from those staff who regularly use any components of the unified records.
8. Ensure records are used in making care, medical treatment, and training decisions.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACE	Angiotensin Converting Enzyme
ACLS	Advance Cardiac Life Support
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
AIMS	Abnormal Involuntary Movement Scale
AMS	Annual Medical Summaries
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BLS	Basic Life Support
BMI	Body Mass Index
BP	Blood Pressure
BS	Blood Sugar
BTC	Behavior Therapy Committee
CAP	Corrective Action Plan
CBC	Complete Blood Count
CCC	Clinical Certificate of Competency
CHF	Congestive Heart Failure
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DCP	Direct Care Professional
DCS	Direct Care Staff
DFPS	Department of Family and Protective Services

DISCUS	Dyskinesia Identification System: Condensed User Scale
DM-ID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DT	Diphtheria and Tetanus
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EENT	Ear, Eye, Nose, and Throat
e.g.	exempli gratia (For Example)
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EPS	Extrapyramidal Symptoms
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
FAST	Functional Analysis Screening Tool
FNP	Family Nurse Practitioner
FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
Hb	Hemoglobin
HBa1	Hemoglobin A1c
HCG	Health Care Guidelines
HCT	Hematocrit
HCTZ	Hydrochlorothiazide
HMP	Health Maintenance Plan
HR	Heart Rate
HRC	Human Rights Committee
HST	Health Status Team
IBWR	Ideal Body Weight Range
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IM	Intra Muscular
IOA	Inter Observer Agreement
ISP	Individual Support Plan
LAR	Legally Authorized Representative

LGS	Lennox-Gastaut Syndrome
LOD	Living Options Discussion
LODR	Living Options Discussion Record
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivation Assessment Scale
MBS	Modified Barium Swallow
MD	Medical Doctor
MG	Milligrams
MERC	Medication Error Review Committee
MHMR	Mental Health and Mental Retardation
MMR	Measles, Mumps, and Rubella
MOSES	Monitoring of Side Effects Scale
MPT	Masters, Physical Therapy
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphyloccus aureus
MS	Master of Science
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NOO	Nurse Operations Officer
NPO	Nil Per Os (nothing by mouth)
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PA	Physician Assistant
PALS	Positive Adaptive Living Survey
PAP	Papanicolau
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PIT	Performance Improvement Team
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan

POI	Plan of Improvement
PPI	Proton Pump Inhibitor
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PST	Personal Support Team
PT	Physical Therapy
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
QSO	Quality System Oversight
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RTC	Return to Clinic
SA	Settlement Agreement
SAM	Self Administration of Medication
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPCI	Safety Plan for Crisis Intervention
SPO	Structured Program Objective
SPOI	Supplemental Plan of Improvement
SSLC	State Supported Living Center
UA	Urinalysis
UIR	Unusual Incident Report
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulation