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 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 (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three 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. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of the State Supported Living Center.

In order to conduct reviews of each of the areas of the Settlement Agreement and Health Care 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 review, 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, at-risk procedures, 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, restraint, 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, recordkeeping, 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 might 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, 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 review. The Monitoring Team made additional requests for documents while onsite.
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 discharge plans (CLDPs), 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 onsite, 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.

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) **Facility Self-Assessment:** No later than 14 calendar days prior to each visit, the facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;

(c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;
(d) **Assessment of Status:** 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 noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. 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. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

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 review. 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 new facility director, Jaime Monardes, was supportive of the monitoring team's activities throughout the week of the onsite review. He was readily available, ensured that all requested information was obtained, and directed all of the

staff to work cooperatively and openly with the monitoring team. For example, he quickly called together relevant mangers and PST members a number of times during the week when there were questions about treatment procedures (for one individual) or when the monitoring team needed more detailed information (e.g., regarding the new risk assessment procedures).

The monitoring team was especially appreciative of the efforts of the new Settlement Agreement Coordinator, Helen Alvarez, and the Settlement Agreement Clerk, Bertha Macias-Muro. They both worked tirelessly during the week of the onsite review (as well as during the weeks immediately proceeding and following the onsite review) to ensure that the monitoring team members were able to obtain the information they needed to conduct this review.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. It is the hope of the monitoring team that the information and recommendations contained in this report are 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 review. 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 second compliance status review of EPSSLC, that is, of the facility's current status in complying with the requirements of the Settlement Agreement.

In addition, the Settlement Agreement required the facility to complete a self-assessment, and to submit it to the Monitor 14 days prior to the onsite review. The facility did so and, in the monitoring report below, the Monitor describes and comments upon the self-assessment steps the facility undertook to self-assess compliance and the results of this self-assessment. This is provided for each of the 20 provisions of the Settlement Agreement. At EPSSLC, the self-assessment document was called the POI (Plan of Improvement). The format of the POI was revised since the last onsite review and was a major and noticeable improvement from the previous more lengthy version.

The POI, however, was completed in mid-December 2010, only two weeks prior to this onsite review. The intent of the POI is that it is completed immediately following the onsite review and then is updated even further once the facility

receives the written report from the Monitor. In this way, the POI can be fully informed by the monitoring team's activities (onsite and written) and line-up with the monitoring team's comments and recommendations.
The Monitor fully understands that this was the facility's first attempt at this new POI and that facility and DADS staff had been working on this new style POI for a number of months. Therefore, the comments regarding the facility's self-assessment in the below sections of this report refer only to the monitoring team's agreement or disagreement with the facility's recent self-ratings. The monitoring team looks forward to the next POI providing more detail, including indicating the specific activities the facility undertook towards achieving substantial compliance with each of the provisions of the Settlement Agreement.

Fourth, many changes had occurred at the facility since the previous onsite review. These are listed below and included a new facility director and new processes. Due, in part, to all of these changes, the monitoring team, overall, did not observe a great deal of progress towards substantial compliance. It is hoped that these leadership changes have created stability so that progress will occur and will be readily evident to the monitoring team in six months.

- Changes in personnel
    - New facility director
    - New settlement agreement coordinator
    - New medical director
    - New psychiatrist
    - New dentist
    - New admissions and placement coordinator
    - New director of quality assurance
    - New (acting) QMRP coordinator
    - New human rights officer and assistant ombudsman
    - All in all, of the 20 provisions of the Settlement Agreement, there was a new EPSSLC manager appointed as the lead for 11 (55%) compared to six months ago.
- Changes in processes and procedures
    - New style PSP documents
    - New style PSP meetings
    - New Community Living Discharge Plan activities and documents
    - New quality assurance activities
    - New assessment and management of individual risk procedures
    - New Physical and Nutritional Management Team procedures
    - New self-advocacy group activities

Fifth, the monitoring team believes that the size, campus layout, and organization of EPSSLC should result in effective communication and integration of services and, ultimately, the attainment of substantial compliance with the many provisions of the Settlement Agreement. Some specific additional topics are briefly discussed below.

- Integration of services. As noted throughout this report, progress and a desire for there to be progress, in the provision of integrated services was noted in a number of areas at the facility. The role of quality assurance should not be underestimated by facility management in the attainment of integrated services. At EPSSLC, however, the monitoring team found a particular lack of collaboration between the nursing department and the QA department. Please see comments in sections L2 and M4 below for more detail. This should be resolved by facility administration as soon as possible.
- Engagement and activities. A lack of variety and number of engaging activities for individuals is noted in many of sections of this report. The facility was aware of this and the new facility director had initiated what was called an Active Treatment Action plan. The monitoring team supports the facility management in this regard, in particular, by encouraging management to begin work on this right away while ensuring that the action plan keeps the process moving along rather than causing delays.
- Direct service staffing. Facility management and facility documents indicated that direct care staffing was "overfilled" at the time of the onsite review by almost 20 positions. Even so, the monitoring team's experience while onsite, however, indicated that there were staffing shortage issues in the homes and day programs. It may be that the overfill calculation was based upon a 1:8 ratio, rather than a 1:4 ratio. Further, the calculation did not take into account that many staff are not present on any particular day due to illness, vacation, training, or other re-assignments. This can create problems for individuals and staff. For example, as discussed further in section C1 below, there were times when shortages of staff in the homes prevented staff from providing consistent and immediate behavior supports and as a result a minor behavior outburst escalates into a crisis. The monitoring team recommends that the facility create a metric that looks at the actual staffing that occurs in each home per shift. That is a metric that reports, per home, the number (or percentage) of shifts in which (a) required staffing was met, and (b) 75% or more of the staff knew the individuals. For example, during the monitoring team's observation of home 509 in the early evening, all four of the assigned staff were not familiar with the individuals (i.e., this was not the home where they regularly worked) and two of the staff reported that they "didn't know much" about the individuals. Whether this was a regularly occurring phenomenon, or an isolated case, was unknown to senior management. Thus, collection of this information may be very informative and useful to senior management. EPSSLC had some success with looking at challenging staffing issues, such as the one-to-one staffing committee described in section G1 below.
- Monitoring tools. EPSSLC had made progress in modifying a number of the monitoring teams' checklist monitoring tools. These modifications made the tools more user-friendly and appropriate for use by facility staff. EPSSLC was working with the central DADS office on this project.

Fifth, a brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full 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

- The facility's restraint trend analysis indicated that there were 227 emergency and programmatic restraints in FY10 and 94 restraints during the quarter prior to the onsite monitoring visit (FY11, 1st quarter). This was a decrease of 10% when compared to the previous quarter, and a 203% increase when compared to the FY10 1st quarter. The number of restraint incidents at EPSSLC had increased steadily since 2009.
- Three areas of focus were identified by the monitoring team during the review week that will be essential in reducing restraints incidents at the facility and are listed below. Administrative staff at EPSSLC reported that these focus areas had been identified and the facility was looking at strategies to address these three areas.
    1. The level of meaningful engagement for individuals at the facility was very low. This lack of meaningful engagement was observed in both the day programs and residential programs throughout the facility.
    2. The implementation of consistent alternative behavioral strategies was not apparent in review of behavioral data. This is addressed in detail in Section K of this report.
    3. An overall philosophy change that restraints will be used as a last resort measure and only as crisis intervention will have to be adopted by both administrative and direct support staff at the facility.
- There were many meetings held to address restraints, however, it was not apparent that recommendations made in meetings were always followed up on and implemented consistently. One example was observed at a PST meeting to address restraints for Individual #13. The team had met numerous times, but behavioral strategies had not been implemented and documented consistently or revised as indicated. For instance, team members were aware that consistent familiar staff support significantly reduced the number of behavior incidents exhibited by Individual #13, but a plan was not in place to provide consistent, familiar staff to him.
- As discussed further in C1 below, a shortage of staff in the homes prohibited staff from providing consistent and immediate behavior supports prior to a behavior escalating into a crisis. Also, poor documentation of factors leading to restraints made it difficult to track and learn from previous antecedents to behavioral crises.

Abuse, Neglect, and Incident Management

- Investigation of 53 cases of abuse, neglect, or exploitation were conducted by DFPS at EPSSLC from 6/1/10 through 11/31/10. These 53 cases included 82 allegations involving 62 individuals identified as potential victims, and 32 staff at EPSSLC identified as possible perpetrators. Of these 82 allegations, 22 (27%) were confirmed by DFPS. Seven (9%) additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The remainder

of the cases included 21 (26%) unconfirmed cases, and 32 (39%) cases referred back to the facility. This was a 14% decrease in the total number of allegations reported compared to FY10 4th quarter.

- There were a total of 349 injuries reported for FY11 1st quarter. This was a decrease of 26% from the 4th quarter in FY10 and a decrease of 8% from the 1st quarter of FY10. Of the 349 injuries reported during FY11 1st quarter, six were considered serious injuries (2%), 237 (68%) were non-serious injuries requiring first aid, and 83 (24%) required no treatment.
- The facility no longer had an incident management coordinator or support staff assigned to this activity. The lead investigator at the facility was assigned to all incident management duties and completed all investigations at the facility. While this investigator was extremely knowledgeable and conscientious in handling investigations, he did not have sufficient time to complete all paperwork and follow-up on all investigations in a timely manner. It appeared that appropriate action was taken to safeguard individuals at the facility when abuse and neglect issues were identified, however, it is possible that the unmanageable workload may compete with this over the long term.

Quality Assurance

- EPSSLC was not in compliance with any of the items of this provision. The QA department had experienced a great deal of turnover since the last monitoring review, including the appointment of a new quality assurance director, and the resignation of two of the three QA program auditors. Only one of the two positions had been filled.
- The QAQI Council was only recently initiated, but had not yet been organized in a manner as directed by the DADS central office. More work will be needed to create guiding policy and procedures, a regular agenda, and a clear set of expectations for the council and its participants, including regular attendance and participation.
- There was no QA plan in place, the QA department did not maintain a listing of all data collected at the facility, a QA report did not exist, and data were not being used by senior management of the facility. Corrective actions were not created or managed in any type of systematic way across the facility. Moreover, the relationship between the facility's single performance improvement team and the QAQIC needed to be clarified for members of both groups.
- The monitoring team, however, was impressed by the QA department's assessment of the reliability of the scoring of monitoring checklists used by the service departments at the facility. This was a regularly occurring activity and the QA department's data analyst regularly tabled and graphed the data.
- Data from an employee satisfaction survey conducted a year ago were available to the facility, but had not been used. Recently (December 2010), the facility had begun to survey families and LARs about their opinions and satisfaction with services. The self-advocacy group had been re-initiated and had met a few times since the

previous monitoring review. Overall, the meetings appeared to touch on topics relevant to self-advocacy and the lives of the individuals.

Integrated Protections, Services, Treatment, and Support

- Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST.
- Administrative staff at EPSSLC had taken some small steps towards evaluating and revamping the service delivery system in regards to active treatment at the facility including:
    - All staff had been trained on the new statewide person centered process for developing PSPs.
    - Beginning implementation of the new statewide person centered planning process.
    - Identifying gaps in present programming and service delivery with input from multiple disciplines
- PST meetings observed the week of the monitoring visit were in the new-style format. For all QMRPs facilitating the meetings, this was a new process for them, as well as for other team members participating in the meetings. At the PSP meetings observed, team members were discussing supports needed in relation to the individual's preferences and interests. While this led to a more integrated plan, there was still not much progress made on identifying outcomes that would support movement towards living and working in a less restrictive environment.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- State policy was not developed or implemented to address these provisions of the Settlement Agreement. The facility had identified the medical director as the lead manager for both provisions, and a number of activities had occurred since the previous review. Moreover, the medical director was knowledgeable about this provision and enthusiastic about the facility's ability to demonstrate integrated clinical care in the near future.
- A number of examples of ways in which EPSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below. It is important that the facility has a specific focus to ensure that all areas of clinical service provision, as specified in provision item G1, are included in the facility's provision of integrated clinical services.
- The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was great desire for there to be 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. It is recommended that the facility's QA department play a role in addressing this provision.

At-Risk Individuals

- The issues and problems in the identification and management of risk that were presented in the previous monitoring report were still occurring at EPSSLC, however, changes were about to occur. The state had taken a number of steps to support an increased likelihood of more positive outcomes in the area of risk management. These included the following:
  - The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began the week of the monitoring visit at EPSSLC. The new policy included changes in evaluating and addressing risks indentified for individuals.
  - Forms had been revised for identifying and a risk action plan to address risk had been developed.
  - Risk Guidelines had been developed to be used by PSTs in rating risk factors.
  - A new initiative was being implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration.
- The hope is that this process will more accurately describe risks for particular individuals and to ensure that services and supports necessary to protect each individual will be put into place.

Psychiatric Care and Services

- The psychiatry department at EPSSLC had undergone a complete change of personnel since the previous monitoring review. The facility has recruited a full time psychiatrist who was new to the practice of psychiatry within a supported living center. The new physician, while excited by the challenge and apparently willing to learn, was in need of mentoring and guidance from a psychiatrist well versed in the provision of services in this environment. It was also noted that the physician, while enthusiastic, was overwhelmed with the current clinical and administrative responsibilities.
- The psychiatrist was not integrated into the overall treatment program at the facility. He was 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. 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.
- The psychiatric clinic sessions were not organized. Space for psychiatry clinic had been identified, and needed to be prepared for the psychiatrist to begin providing services there. Evaluations and diagnostic assessments were not yet following the requirements of Appendix B, however, there was intention to do so.

- While psychiatry was interacting with psychology on some levels, it was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration.
- Nevertheless, what was most striking during this review, was that staff overall were caring and invested in the treatment of the individuals and had a desire to see the individuals benefit from treatment.

Psychological Care and Services

- Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, there was progress in several items. These included the development of the skills and management competencies of the Director of Psychology (Behavioral Services), the establishment of internal peer review, several improvements to the data collection system, the beginning of functional assessments, the continued development of goal directed psychological therapies with measurable objectives and treatment expectations, the modifications of some Positive Behavior Support Plans (PBSPs) reflecting data-based decisions, and the beginning of individualized graphing of target behaviors at intervals adequate for interpretation.
- There were also areas that the monitoring team believes required immediate attention. Those areas included ensuring that all psychologists are enrolled in coursework toward becoming a board certified behavior analyst, ensuring that all target behavior and replacement behaviors are collected with integrity, ensuring that PBSPs include specific and precise interventions, based on the results of functional assessments, for decreasing undesired behavior, systematic training of all direct care professionals in the implementations of each individuals PBSP, and ensuring that PBSPs are implemented with integrity.

Medical Care

- Progress from the previous monitoring visit was seen in several areas. The previous medical director retired at the end of October 2010. The new medical director assumed the responsibilities on 9/1/10. A full time psychiatrist was hired and a joint neurology-psychiatry clinic was scheduled to begin. The advanced practice nurse continued to assist the medical director with completing annual medical summaries, but she had reduced her hours to 8-16 hours per week resulting in less primary care coverage.
- Under the leadership of the medical director, several positive changes were underway in the department. Documentation of medical care and hospital follow-up had improved. Clinical guidelines had been developed to aid in the provision of medical care. A hospital return policy had also been drafted. The use of pretreatment sedation at the facility was under review and the numbers of individuals receiving sedation for medical and dental procedures was decreasing.

- There had not been an external review of medical services. There were serious issues with the mortality review process. First, there was a significant delay of five months prior to completion of the clinical death reviews and no administrative death reviews had occurred. Moreover, the clinical death reviews that were completed did not appear to take into consideration valid recommendations that were provided by internal reviewers. There was no mechanism in place to demonstrate what actions had occurred as a result of mortality reviews.
- The facility had not implemented a medical quality review system but development was expected to begin after the clinical guidelines, which outlined the expectations of care, were implemented.

Nursing Care

- EPSSLC nurses were diligently working in the midst of numerous changes and challenges, including the loss of several nursing management staff members (e.g., Nurse Liaison, Nurse Educator, Campus Nurse Supervisor, Nurse Manager). Even so, nurses received re-training and re-education in documentation of progress notes, assessments, and care plans. In addition, the nursing department changed the format of the Individual Progress Notes (IPNs) to SOAP (subjective and objective data, assessment, and plan) format. Nonetheless, a review of records revealed that since the prior review, the legibility of nurses' notes, signatures, and credentials had declined. Also, the conduct of the shift-to-shift report and the documentation of an informative 24-hour shift report continued to need improvement in order to become a reliable method of communicating individuals' significant changes in health status from one shift to the next.
- Quarterly and annual nursing assessments existed in each of the 20 sample individuals' records, but the majority did not have accurate, complete, comprehensive assessments that resulted in complete lists of nursing diagnoses, such that care plans/interventions could be properly developed and/or updated. There were also many individuals who suffered significant changes in their health status between quarterly assessment periods (e.g., hospitalizations, serious illnesses, and injuries affecting health status, functioning, and overall health and well-being) whose assessments were not updated.
- All individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Acute Care Plans (ACPs). The nursing department, however, failed to consistently (a) incorporate all relevant data from systems' assessments into the HMPs and ACPs, (b) reference all health risks and actual problems in the HMPs and ACPs, and (c) update HMPs and ACPs as needed to ensure they addressed all current health needs at all times.

Pharmacy Services and Safe Medication Practices

- There was progress noted in every provision item since the previous onsite review. In many instances, however, programs and processes had been implemented in the weeks just prior to the onsite review resulting in limited data and/or information for review.

- The pharmacy began documentation of physician contact in September 2010. Drug regimen reviews were completed in a timely manner, but there were issues related to the content and consistency of data elements reported. There was also no mechanism in place to track physician implementation in those cases where there was agreement with pharmacy recommendations. The Polypharmacy Oversight Committee had one meeting prior to the onsite review and discussions of that meeting had not been formally documented.
- The DUE system was implemented, but the selection of drugs for review was not consistent with the recommendations of the Health Care Guidelines that specifically required that high use, high risk drugs be targeted initially. The revised ADR system had been implemented just weeks prior to the onsite visit which resulted in reporting of only one month of data. The MOSES and DISCUS rating tools were being completed in a timely manner. More problematic was the lack of any real physicians response as well as delays in physician response.
- Medication errors of omission remained problematic with hundreds of medications (not even including liquids, drops, and ointments) being returned to the pharmacy. The downward trend for the second half of the year culminated with a significant increase in returns during the month of December 2010. Although this information was reported to the facility's QA Department, there had been no apparent response to the problem.

Physical and Nutritional Management

- A notable area of improvement was in the area of transfers, though refreshers related to staff body mechanics was an ongoing need. Improvements were also evident during mealtimes, though there continued to be concerns noted during observations by the monitoring team.
- Monitoring had increased and training as well as validation of monitors had been ongoing, but even the internal analysis of compliance with the process identified numerous errors. PNMPCs were observed to be monitoring, but did not identify several issues related to diet texture, liquid consistency, or implementation of the Dining Plan in one home and did not intervene appropriately. EPSSLC is congratulated on their efforts to self-assess and use the feedback to guide training, but the process was new and ongoing review was indicated.
- The PNMT process was initiated, but there was no assigned OT or nurse because these staff had recently resigned. There will be a significant period of growth as they attempt to clearly establish roles and responsibilities. The initial meetings observed were examples of these growing pains and, in one case, the PNMT actually usurped what should have been PST roles and this will need to be clarified. The PNMT should take on a role of assessment and analysis and this should not be limited to a meeting only format. Extensive assessment, staff interview, and observation will be critical to the successful design of appropriate interventions. The PNMT must collaborate and be well integrated with the PST, but should not take on PST functions. The PNMT is an adjunct resource, not intended to replace the PST process. There was a need for a well-outlined agenda to keep the meetings on track and moving along. This process in conjunction with the newly implemented At Risk Individuals policy will require extensive review during future onsite reviews.

Physical and Occupational Therapy

- Since the last review, the focus for OT/PT had been related to a focus on measurable outcomes and the provision of staff training. The assessment format was revised to include potential for skill acquisition and to attempt to integrate risk issues into the assessment. Too often, however, deficits were viewed as barriers to skill acquisition rather than as opportunities for intervention and training. There continued to be insufficient comparative analysis related to progress or regression from the previous assessment. While clinicians appeared to promptly address issue-specific or problem-oriented concerns for individuals, the documentation was in a separate assessment and not in the Integrated Progress Notes for ready access by other team members. In addition, the very few interventions provided by therapies were not integrated into the PST process itself.
- In general, however, it appeared that staff were attending better to the details of proper positioning and compliance with the PNMPs and implementation was improved since the previous onsite review. The PNMPCs, however, were not consistently observed to identify and intervene as issues came up related to direct support staff implementation of the PNMP.
- The PTs took leadership roles in many aspects of the department and appeared to have strong clinical skills. The OT staffing continued to be a significant concern. The single OT employed previously had resigned and there was a very part-time OT and a new graduate along with the two COTAs. It is imperative that staffing in this area be increased and that there is sufficient support to ensure that the newly graduated OT is successful in this environment.
- The clinical staff appeared to work well together and presented with a strong knowledge base relative to therapy clinical information. There was a need to tighten up their systems and documentation.

Dental Services

- The new dental clinic at EPSSLC opened in May 2010, but the professional services of a dentist were not available until September 2010. Prior to September 2010, individuals were assessed by the hygienists and were seen in the community or in the dental clinic when a dentist from another SSLC was available. The addition of a dentist and dental assistant was progress. The format of dental data submitted to the monitoring team was insufficient to clearly demonstrate the extent of dental services provided at EPSSLC. For example, the spreadsheet that contained all data elements for all individuals supported by the facility included pages that duplicated data, and had different cottage numbers.
- Record reviews and interviews, however, indicated that the individuals were beginning to receive more regular dental treatment. Initial assessments were being completed along with plans for future treatment. The facility

had also recently implemented the use of suction toothbrushes and chlorhexadine for those individuals with enteral nutrition.

- The clinic staff reported there was no significant issue with failed appointments, yet refusals and missed appointments were documented. More importantly, a lack of recognition of this problem resulted in a failure to implement strategies to address the issue of failed appointments, especially given that 34% of the individuals had poor oral hygiene ratings.
- The use of pretreatment sedation was limited to those individuals with off campus appointments. In spite of concerns related to sedation, there were no formal desensitization plans in place at the time of the onsite visit. The majority of dental assessments indicated that sedation or general anesthesia was needed to complete exams and treatment.

Communication

- Many individuals who needed AAC and other communication supports and services did not receive them. There were at least 84 individuals who were identified as nonverbal and, though others were listed as verbal, a number of them did not appear to be functional communicators in a variety of contexts and environments and should have instead been considered to have significant communication limitations. It was of concern that only 4% (five out of 134) of the individuals living at EPSSLC received direct communication services (2% of those who were considered non-verbal). No more than 18 individuals had individual AAC devices provided to them.
- While it was great that community systems (e.g., wallboards) had been provided, the focus needed to shift to more individual systems that were meaningful and functional. A few AAC assessments had been completed that appeared to yield more individualized and functional supports for communication, including AAC systems, and were significantly more thorough. It was of great concern to the monitoring team that so little had been done in the last six months to address this area.
- The Communication Skills assessment format had been revised, yet the content in many cases was far from thorough. In most cases, the assessments did not address expansion of current abilities or the development of new skills beyond the standard Communication Books and the Communication Picture Wallboards. There was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish individual 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. The issue of integrating communication issues with the Behavior Support Plan was not being adequately addressed.
- There was no Master Plan related to how the facility had prioritized completion of comprehensive assessments to identify and provide appropriate interventions, AAC, and other communication supports for the individuals living at EPSSLC. Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occur in order to promote

communication skill acquisition. There were few, if any, formal communication programs (as also noted in sections F, S, and T of this report).

Habilitation, Training, Education, and Skill Acquisition Programs

- This provision incorporates a wide variety of aspects of programming including 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.
- Although no items of this provision were found to be in substantial compliance, there were some positive developments since the last review. These included that the facility had begun to improve the incorporation and documentation of individual's needs and preferences into the development of SPOs, and psychologists were beginning to write SPOs for medical desensitization. Day programming had recently been modified to improve individual engagement, and individual engagement scores for the facility had improved. DCPs had received training in the effective use of behavioral methodologies for the acquisition of skills.

Most Integrated Setting Practices

- EPSSLC had not made much progress in meeting the items of this provision. A new admissions and placement coordinator had only recently been assigned and state policies and procedures were in the process of revision. Some progress, however, was seen in the PSP process. More individualized and participatory discussion occurred at the PSP meetings observed by the monitoring team compared to the PSP meetings observed during the previous onsite review.
- The number of individuals placed in the community was low, only one placement occurred since the last onsite review. One individual was scheduled to move within the upcoming month and others were on the referral list, some for more than six months. On the other hand, two individuals were referred recently, including one during a PSP meeting observed by the monitoring team. The facility needed to do more tracking of individuals in relation to obstacles to referral. For example, the facility did not have a list of individuals for whom LAR preference was the only reason for he or she not being referred for placement.
- EPSSLC continued to engage in activities to educate individuals and their families or guardians to make informed choices, however, it should consider ways of assessing the effects of these activities and making improvements. For example, outcomes of the provider Summer of Discovery activities and the CLOIP activities should be determined and the effectiveness of these activities assessed. Further, as noted below, more work should be done on the system of community tours, and the self-advocacy group could be used as an opportunity to educate individuals about community placement.

- The CLDP process was also being revised. Comments are provided regarding the proposed new CLDP and post-move monitoring forms and procedures. A continuing problem was the absence of the inclusion of individualized and meaningful essential and nonessential supports within the CLDP. The ability of PSTs to play a more active role was needed.
- Post move monitoring was occurring. The post move monitor conducted visits to both the day program and residence of each individual for each of the three required post move monitorings. Due to the few placements completed by EPSSLC, few post move monitoring visits were required. All were done according to schedule and using the required form. There continued, however, to be a need for more detailed descriptions of essential and nonessential supports, so that they could be observed and so that the post-move monitor would know what was required to indicate evidence of the presence of the support. A visit by the monitoring team to a home for a 90-day post-move monitoring visit occurred. Important information was obtained and the post move monitor conducted the visit in a professional and organized manner. Improvements, however, were needed to ensure that adequate evidence was observed to indicate the presence of each support. The new post move monitoring form was used for this 90-day visit observed by the monitoring team. A number of problems with this new form were identified by the monitoring team. These problems led to there being less information now being reported by the post move monitor compared to what was reported on the old form.

Consent

- EPSSLC indicated it was waiting on the final statewide policy and training before taking most actions. Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, not all individuals had been assessed and not all PSTs were adequately addressing the need for a LAR or advocate. Provision item U2 was determined to be in noncompliance. The facility reported little activity or planning to solicit guardians for those determined to be in need. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite.
- The facility had an active Human Rights Committee in place to review restrictions requested by the PST. Some PSTs were holding good discussions around the need for guardians while other teams were only minimally discussing the capacity for individuals to make decisions and give consent.

Recordkeeping and General Plan Implementation

- EPSSLC made progress towards meeting this provision. The new policy and recordkeeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. A master record, however, was not adequately in place and needed to be. A small number of errors were found in a review of the active records, indicating the need for ongoing reviews and audits, as were just being initiated at the facility.

- EPSSLC had conducted a staff survey as recommended in the previous monitoring report. Data now needed to be summarized, assessed, and acted upon. Overall, the survey indicated satisfaction with the new recordkeeping practices at the facility (although, as noted below, during interviews with staff some potential problems were identified).
- Audits as per provision item V3 had begun in September 2010. The audit system, however, required improvement to ensure that all contents were reviewed as per the table of contents, and that all components of the unified record were reviewed, including the individual notebook and master record. In addition, a system was needed to ensure that corrections were made to the records based on the audits.
- The facility had made an initial attempt to address provision V4, the usage of records in making care and treatment decisions by requiring the facility's many disciplines to make entries in the integrated progress notes. As noted below, this may be one component of the way this provision is assessed, but it is likely to be insufficient to meet this provision item's requirements.

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:

- EPSSLC Use of Restraint Policy dated 8/31/09
- Training Curriculum for RES0300 Restraint: Ordering, Assessing, and Evaluating
- Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities
- A list of all restraint for crisis intervention from 5/1/10-11/20/10
- A list of all medical and dental restraints from 7/1/10-10/31/10
- PMAB Training Curriculum
- Exception list showing all staff who are required to, but have not completed training on the use of restraints as mandated by state policy
- Training transcripts for 24 EPSSLC employees
- Human Rights Committee meeting minutes from 8/1/10 through 11/3/10
- Restraint Reduction Committee meeting minutes from 4/22/10 – 9/30/10
- Summary report by Valerie Grigg of visit to San Antonio SSLC to discuss restraint reduction.
- Restraint Trend Analysis Report for June 2010 through November 2010
- Dental desensitization plans for:
  - Individual #23, Individual #50, Individual #105, Individual #88, Individual #157, Individual #107, Individual #21, Individual #71, Individual #76, and Individual #32
- A sample of restraint documentation including:

Individual	Date/Type	Restraint Checklist	Face to Face Debriefing	PSP Addendum(A)	PBSP	Safety Plan
#104	12/4/10 Physical	x	x	6/10/10	7/12/10	11/1/10
	11/20/10 Physical, Chemical	x	x			
	11/5/10 Physical	x	x			
	10/30/10 Physical	x	x			
	10/21/10 Physical	x	x			
	10/8/10 Physical	x	x			
	9/22/10 Physical	x	x			
	8/6/10 Physical	x	x			
#13	12/23/10 Physical	x	x	3/23/10	4/1/10	7/6/10

	11/4/10 Physical	x	x	10/15/10 (A) 10/19/10 (A) 10/25/10 (A) 11/1/10 (A) 11/8/10 (A) 11/10/10(A) 11/16/10(A)		
	11/4/10 Physical	x	x			
	10/30/10 Physical	x	x			
	10/22/10 Physical	x	x			
	10/14/10 Physical	x	x			
	10/13/10 Physical	x	x			
	10/3/10 Physical	x	x			
	9/21/10 Physical	x	x			
#109	11/11/10 Physical	x	x	11/23/10		
	10/15/10 Physical	x	x			
	8/31/10 Physical	x	x			
	8/25/10 Dental	x	x			
	8/9/10 Physical	x	x			
	9/19/10 Physical	x	x			
	11/4/10 Physical	x	x			
#39	12/8/10 Physical	x	x	5/19/10 11/17/10(A) 11/9/10(A) 11/5/10(A) 10/26/10(A) 10/25/10 (A) 10/20/10 (A) 9/29/10(A)	3/11/10	9/9/10
	11/16/10 Physical	x	x			
	10/25/10 Physical	x	x			
	10/20/10 Physical	x	x			
	9/28/10 Physical	x				
	9/8/10 Physical	x	x			
	8/23/10 Physical	x	x			
	8/23/10 Physical	x	x			
	8/16/10 Physical	x	x			
#38	10/31/10 Physical	x		3/1/10	3/27/10	
#73	11/5/10 Physical	x	x	6/17/10	6/17/10	
#112	10/11/10 Physical	x	x	12/15/09	1/13/10	
#76	11/19/10 Dental	x				
#100	11/29/10 Dental	x				
#89	11/18/10 Dental	x				
#8	11/17/10 Chemical	x	x	12/14/09	12/9/09	
	11/10/10 Chemical	x				
	11/10/10 Chemical	x				

<u>Interviews and Meetings Held</u>:

- Interviews with various direct support staff in homes and day programs
- Jaime Monardes, Facility Director
- Gloria Loya, Human Rights Officer
- Valerie Grigg, Director of Behavioral Services
- Julie Norman, Training Specialist

	o Cynthia Martinez, QMRP Coordinator Observations Conducted: o Observations at all residences o Observations at all day programs o Daily Incident Management Review Team Meeting 1/4/11 o PSPA meeting for Individual #13
	Facility Self-Assessment: The facility's Plan of Improvement for section C indicated that the facility had appropriate policies regarding restraints in place, but was not in compliance with those policies. The monitoring team agreed with this assessment. The facility did have a plan for addressing deficits in the area of restraints, but acknowledged that they were in the beginning stages of compliance.
	Summary of Monitor's Assessment: The facility gathered and analyzed data on restraints monthly and produced both a monthly and an annual report that looked at restraint types, individuals and staff involved, residential units, locations of the restraints, and the days of the week/shifts when the restraints occurred. The facility's restraint trend analysis indicated that there had been a total of 227 emergency and programmatic restraints utilized at the facility in FY10. There had been 94 total restraint incidents at the facility during the quarter prior to the onsite monitoring visit (FY11, 1st quarter). This was a decrease of 10% when compared to the previous quarter and a 203% increase when compared to the FY10 1st quarter. The number of restraint incidents at EPSSLC had increased steadily since 2009. The facility was looking at restraint reduction, in particular the psychology department relayed to the monitoring team that restraint reduction was a priority at the facility. Three areas of focus were identified by the monitoring team during the review week that will be essential in reducing restraints incidents at the facility. 1. The level of meaningful engagement for individuals at the facility was very low. This lack of meaningful engagement was observed in both the day programs and residential programs throughout the facility during the week of the monitoring visit. 2. The implementation of behavioral strategies as per PBSPs. This is addressed in detail in Section K of this report. 3. An overall philosophy change that restraints will be used as a last resort measure and only as crisis intervention will have to be adopted by both administrative and direct support staff at the facility. Administrative staff at EPSSLC reported that these focus areas had been identified by psychology staff and the facility was reportedly looking at strategies to address these three areas. There were many meetings frequently held at the facility to address restraint incidents, including PST

	meetings for individuals involved in restraints, Restraint Reduction Committee meetings, daily Incident Management Review Team (IMRT) meetings, and Human Rights Committee (HRC) meetings. It was not, however, apparent that recommendations made in meetings regarding restraints were always followed up on and implemented consistently. One clear example of this was observed at a PST meeting to address restraints for Individual #13. The team had met numerous times to review restraint incidents, but behavioral strategies had not been implemented and documented consistently or revised as indicated. For instance, team members were aware that consistent familiar staff support significantly reduced the number of behavior incidents experienced by Individual #13, but a plan was not in place to provide consistent, familiar staff to support him. As discussed further in C1 below, a shortage of staff in the homes prohibited staff from providing consistent and immediate behavior supports prior to a behavior escalating into a crisis. Additionally, poor documentation of incidents leading to restraints made it difficult to track and learn from previous antecedents to behavioral crisis for individuals at the facility.

#	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.	Based on information provided by the facility in a list of all restraints used for crisis intervention, between 5/1/10, and 10/31/10: • 22 individuals were the subject of restraints, • 192 restraints occurred, • 0 of these were mechanical restraints, • 130 (68%)of these were physical holds, • 62 (32%)of these were chemical restraints, • 95 (49%)of these were emergency restraints, and • 97 (51%)of these were programmatic restraints. The facility provided a list of all medical and dental restraints between 7/1/10 and 10/31/10: • 33 restraints occurred, • 27 of these were dental restraints involving 25 individuals, and • 6 of these were medical restraints. The monitoring team requested a list of individuals who had been restrained for medical or dental procedures. The list provided to the monitoring team did not include all individuals who had been restrained as evidenced by HRC minutes that named additional individuals for whom medical and dental restraints had been used. The monitoring team also requested a list of individuals at the facility who had desensitization plans in place. The facility provided a file containing 10 desensitization plans in response to this request. Additional plans were found to be in place, though not	Noncompliance

#	Provision	Assessment of Status	Compliance

		included in plans provided to the monitoring team
		It was not evident that the facility could provide an accurate list of individuals for whom restraints were being implemented for medical and dental procedures and which of these individuals had desensitization plans in place. The facility needs to track all incidents of medical and dental restraints and ensure that desensitization plans are in place for individuals when the PST determines a need for medical or dental sedation.
		
		<u>Prone Restraint</u>
		Based on facility policy review, prone restraint was prohibited.
		
		Based on review of other documentation, including a list of all restraints and a sample of restraint checklist prone restraint was not identified.
		
		A sample, referred to as Sample #C.1, was selected. This included eight individuals, representing 37% of individuals involved in restraint incidents over the previous two quarters. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included: Individual #8, Individual #13, Individual #38, Individual #73, Individual #112, Individual #39, Individual #104, and Individual #109
		
		Based on a review of the restraint records for individuals in Sample #C.1 involving eight individuals, 0 (0%) showed use of prone restraint.
		
		<u>Other Restraint Requirements</u>
		Based on document review, the Facility policies did state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.
		
		Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review:
		• In 37 of the 40 records (93%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. Examples of where this was the case included:
		  o The restraint checklist for Individual #104 on 10/21/10 indicated that he posed an immediate danger to himself. According to the restraint checklist, he was hitting his head against the wall prior to the restraint.
		  o The restraint checklist for Individual #38 on 10/31/10 indicated that a hand and arm hold was implemented because he was hitting his ears	

#	Provision	Assessment of Status	Compliance
		with his fist. o The restraint checklist for Individual #73 indicated that a hand hold was implemented when he became "aggressive towards staff and was scratching himself and pulling his hair." Examples where this was not the case included: o A restraint checklist for Individual #13 on 10/13/10 did not include a description of the behaviors leading up to the restraint. o The restraint checklist for Individual #104 on 12/4/10 indicated that he was "trying to grab peers." o The restraint checklist for Individual #109 on 8/9/10 indicated that he began attacking direct care staff, though the reason for restraint was marked as self-injurious behavior. Aggression towards staff or self injurious behavior was indicated as the reason for the restraint on most forms. It was difficult to determine whether or not the individual posed an immediate or serious risk to self or others because comments were limited in describing behavior prior to implementation of the restraint. • For the 40 restraint records in the sample, a review of the descriptions of the events leading to behavior that resulted in restraint found that eight (20%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. A majority of the checklists reviewed described the individual's behavior prior to the restraint, but did not describe events leading up to or causing the behavior. Eight of the checklists gave a brief description of events that occurred prior to the restraint. This information would be useful for direct care staff to know to avoid future restraint incidents. Examples of good documentation included: o The restraint checklist for Individual #13 dated 11/5/10 indicated that he became aggressive towards staff when he attempted to go to the patio area and found the door was locked. o The restraint checklist for Individual #13 dated 9/21/10 indicated that he became aggressive after staff told him he could not have pizza. Examples where this was not the case included: o In the area for the description of events on the restraint checklist for Individual #109 on 11/4/10, staff stated "became aggressive towards staff." There is no indication what led to the aggressive behavior. o On the restraint checklist for Individual #104, staff wrote "SIB, attacking staff" in the area describing events leading to the behavior resulting in restraint. o The restraint checklist for Individual #104 on 10/21/10 indicated that he was hitting his head against the wall, but did not describe events occurring prior to this behavior.	

#	Provision	Assessment of Status	Compliance
		- In 21 of the records (53%), there was evidence that restraint was used only after a graduated range of less restrictive measures had at least been attempted or considered in a clinically justifiable manner. Examples where this was the case included: - The restraint list for Individual #8 dated 11/17/10 indicated that staff attempted a series of interventions to avoid restraint, including replacement behavior, interventions in his PBSP, verbal prompts, redirection, removing dangerous objects, trading out staff, and environmental changes. Least restrictive physical holds were attempted prior to chemical restraint. - The restraint checklist for Individual #104 dated 11/20/10 indicated that staff attempted redirection by offering snack and a shower. The form also indicated that verbal prompts, moving away from the individual, and trading out staff were attempted prior to restraint. - The restraint checklist for Individual #104 dated 8/6/10 indicated that staff attempted several strategies including offering a snack and a change of environment prior to restraint. Examples where this was not the case included: - The restraint checklist for Individual #112 dated 10/11/10 indicated that PMAB protective skills were implemented along with verbal redirection prior to a basket hold and then horizontal restraint. The checklist did not clearly indicate what steps staff took prior to restraint to deescalate the behavior. - The restraint checklist for Individual #8 dated 11/10/10 indicated that staff attempted verbal prompt and redirection prior to administering a chemical restraint. There was no indication that less restrictive strategies were exhausted prior to using chemical restraint. - The restraint checklist for Individual #104 dated 11/5/10 indicated that the individual was placed in a horizontal hold following attempts at redirection without attempting a less restrictive physical hold. It was not clear that all restraints used were the least restrictive intervention necessary. Without good documentation of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the restraint was applied to allow a determination to be made that the procedures were the least restrictive necessary. During observations at homes during the evening hours, it was evident that there were not always enough staff on duty to implement appropriate behavioral strategies prior to a behavior escalating. At cottage 508, it was observed that an individual was on the front	

#	Provision	Assessment of Status	Compliance
		porch upset and screaming when members of the monitoring team entered the home. Direct support staff were all busy providing supports to individuals in the home and unable to go outside to intervene with the individual on the porch. Another individual was requesting something to drink. Staff had to tell her to wait. Staff called a "code yellow" and psychology staff came to talk with the individual on the porch. Psychology staff coaxed the individual to come inside then left to deal with another crisis in another cottage. The individual later went back outside and started screaming again; psychology staff was called to intervene for a second time. Informal interviews with direct support staff indicated that "code yellows" were routinely used in place of direct support staff intervention. This shortage of support staff and reliance on using psychology staff to intervene in behavior crisis prohibits direct support staff from being able to practice appropriate behavior intervention skills and intervene early enough to de-escalate behaviors before they reach a crisis level. In addition, only nine of the 40 restraints in the sample included a signature showing review by the psychologist. Facility policies identified a list of approved restraints techniques. • Based on the review of 40 restraints, involving eight individuals, 40 (100%) were approved restraints techniques. An investigation reviewed in the sample for section D of this report indicated that staff reported an allegation of abuse after witnessing a direct support staff implement a restraint technique not approved by the facility policy. The allegation of abuse was confirmed and the alleged perpetrator was dismissed indicating that the facility did enforce mandates to only use approved restraint techniques. Observation of all residential and day programs during the monitoring visit indicated that individuals were not engaged in meaningful interesting activity throughout much of the day. As discussed in detail in sections S and K, outcomes in SPOs and strategies in PBSPs were not implemented consistently and progress was not consistently documented and used to revise plans as necessary. Therefore, it was not apparent that restraint was not being used in the absence of or as an alternative to treatment at the facility. Interviews with psychology staff and staff responsible for implementation of plans confirmed that staff were aware of this lack of meaningful engagement and agreed that it impacted behavior management strategies at the facility. The monitoring team met with the chair of the restraint reduction committee. She reported that she had visited the San Antonio SSLC as part of EPSSLC's work towards making facility-wide changes required to accomplish a meaningful reduction in restraint use at EPSSLC (e.g., approaches to restraint reduction and increase in activity	

#	Provision	Assessment of Status	Compliance
		engagement). The facility is not in compliance with this provision item.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the eight individuals in Sample #C.1 were reviewed. Of these, four of the individuals had Safety Plans that defined the use of restraint. A sample of restraint documentation was reviewed for the following individuals to determine if the individual was released from restraint according to criteria set forth in the Safety Plan: • For Individual #13, his Safety Plan included strategies for timed release of restraint at six minutes regardless of behavior exhibited at the time of release. Of 11 restraint incidents reviewed, 10 (91%) indicated that the individual was released from restraint according to the criteria set forth in the Safety Plan. Staff did not consistently document the correct code for release according to the Safety Plan. For example: o A restraint incident on 11/4/10 contained conflicting information on release time. The action release code section indicated that the restraint began at 6:08 pm and he was released at 7:02 pm with the code "J" for met Safety Plan definition for release. o A restraint incident on 12/23/10 indicated that he was released six minutes from the beginning of the restraint, but is coded "M" for release attempted and unsuccessful. o A restraint incident on 11/13/10 indicated that the individual was released after six minutes due to injury. Only one of the 11 restraint forms for Individual #13 included a description of his behavior at the time of release. This information should be included in order to determine if release strategies in the Safety Plan are effective. • For Individual #39, five of the restraint incidents in the sample occurred after the development of his Safety Plan dated 9/9/10. Of those five, one (20%) indicated that staff followed instructions for timed release at four minutes regardless of his behavior as instructed in his Safety Plan. o Examples where he was released according to his Safety Plan included restraint checklist dated: 12/28/10 o Examples of documentation showing that he was not released according to criteria in his Safety Plan included 9/28/10, 10/20/10, 10/25/10, and 11/16/10. • For Individual #104, three of the restraint incidents in the sample occurred following development of his Safety Plan on 11/1/10. All three (100%) of the	Noncompliance

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		restraint checklist reviewed indicated that he was released from restraint according to criteria in his Safety Plan. • For individuals in the sample who did not have Safety Plans, three (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to himself or herself. All three restraint documents in this sample included the release code "L" indicating that the individual was released immediately when no longer immediate and serious risk of harm to self or others. The sample included the following restraint incidents: o Individual #112 dated 10/11/10, three minutes in duration o Individual #73 dated 11/5/10, l three minutes in duration o Individual #38 dated 10/31/10, six minutes in duration All restraint documents should clearly indicate the individual's behavior at time of release from restraints. Due to the variation in how staff were coding behavior at the time of release, it was not possible to determine that individuals were released as soon as they no longer presented a danger. Staff need additional training on the use of restraint forms and the importance of making correct entries, and restraint monitors need to carefully review the checklist before approving it. The facility was not in compliance with this provision.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. This sample included 24 current employees at the facility A review of training transcripts, including their start dates, the dates on which they were assigned to work with individuals, and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that 15 out of 24 staff (62%) had received training on restraint and its related topics every 12 months as required. For the other nine employees:	Noncompliance

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	redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	• Four did not have current training, and • Five had current training on the use of restraints, but refresher training was not, at some point, completed within 12 months of previous restraint training as required. Training transcripts reviewed for employees in the sample indicated that four (17%) of the 24 did not have PMAB training within 12 months of previous PMAB training. A list of employees delinquent in training indicated that fourteen medical staff at the facility required to have RES0300 Restraint: Ordering, Assessing, and Evaluating were delinquent in receiving this training. This list consisted of medical staff responsible for ordering and monitoring restraints. As noted above with regard to Section C.1 of the Settlement Agreement, 53% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been attempted or considered in a clinically justifiable manner. The facility needs to ensure that employees complete training on the all elements of restraint at least every 12 months after initial training. The facility is not in compliance with this provision item.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 40 restraint records (Sample #C.1), 37 (93%) indicated that restraint was used as a crisis intervention. On three restraint checklists for Individual #104 (dated 10/8/10, 11/5/10, and 12/4/10), staff did not mark the type of restraint on the restraint checklist. Facility policy did not allow for the use of restraint for reasons other than crisis intervention. PSPs and PBSPs were reviewed for seven individuals in the sample. None of the individual had "Do Not Restrain" orders in place. In six of seven records reviewed (86%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders or recommendations from other team members. Individual #73 was restrained using a physical hand hold on 11/5/10. Her PSP and BSP did not indicate that she should not be restrained though she has osteopenia and was rated as high risk by habilitation therapy for risk of injury and fractures. Her PSP included the recommendation from PT to reduce the risk of injury/fractures from brittle bones through careful handling.	Noncompliance

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		In reviewing seven (21%) PSPs for individuals identified by the facility in a sample of 33 for whom restraint had been used for the completion of medical or dental work: • Seven (100%) showed that there had been appropriate authorization (i.e., HRC approval and adequate consent), and • Seven (100%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. Examples where this was the case included: o Individual #76 received pretreatment sedation for a dental cleaning on 11/19/10. He has a dental desensitization plan in place. o Individual #109 required pretreatment sedation for medical and dental appointments. His PSP included desensitization outcomes for both medical and dental treatment. The facility needs to review the possible risk factors associated with restraint for each individual and ensure that staff are aware of individuals for whom restraint should not be implemented. As discussed in the summary for section C, it was not evident that staff were familiar with or had consistently implemented other strategies that might prevent a restraint incident prior to implementation of the restraint. The facility is not in compliance with this provision.	
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	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on a review of 40 restraint records (Sample #C.1), a face-to-face assessment was conducted: • In 35 out of 40 incidents of restraint (88%), there was assessment by a restraint monitor. Records that did not contain documentation of this included: o Individual #104 10/8/10 o Individual #38 10/31/10 o Individual #39 8/16/10 o Individual #39 9/28/10 o Individual #13 12/23/10 • In 27 out of 40 instances (68%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: o Individual #13 11/20/10 (did not document time of assessment)	Noncompliance

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	start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	o Individual #109 9/19/10 (did not document time of assessment) o Individual #104 10/8/10 (no assessment) o Individual #13 11/5/10 (did not document time of assessment) o Individual #13 9/21/10 (did not document time of assessment) o Individual #38 10/31/10 (no assessment) o Individual #8 11/17/10 (late) o Individual #13 10/3/10 (did not document time of assessment) o Individual #39 8/16/10 (no assessment) o Individual #39 11/16/10 (did not document time of assessment) o Individual #39 10/20/10 (did not document time of assessment) o Individual #39 10/25/10 (did not document time of assessment) o Individual #39 9/28/10 (no assessment) • In 33 instances (83%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included: o Individual #104 10/8/10 o Individual #38 10/31/10 o Individual #13 10/3/10 o Individual #39 8/16/10 o Individual #39 10/20/10 (incomplete) o Individual #39 9/28/10 o Individual #13 12/23/10 • In 32 instances (80%), the documentation showed that an assessment was completed of the circumstances of the restraint. Records that did not contain documentation of this included: o Individual #104 10/8/10 o Individual #38 10/31/10 o Individual #13 10/3/10 o Individual #39 8/16/10 o Individual #39 10/20/10 (incomplete) o Individual #13 9/21/10 (incomplete) o Individual #39 9/28/10 o Individual #13 12/23/10 There were no records in the sample for which physicians had ordered alternative monitoring schedules for restraint. Based on a review of 40 behavioral restraint records for restraints that occurred at the facility there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the	

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		restraint in 12 (30%) of the instance of restraint. Many of the restraint checklists indicated that a nursing assessment did not occur until more than 30 minutes after the restraint was initiated. Restraint records where this did not occur included: o Individual #109 on 8/9/10 (late), 9/19/10, 11/11/10 (late), and 10/15/10 (recorded prior to restraint, no post restraint assessment) o Individual #38 on 10/31/10 (late) o Individual #104 on 12/1/10, 11/20/10 (late), 11/5/10 (late), 10/30/10, and 10/8/10 o Individual #13 on 12/23/10 (late), 11/13/10 (late), 11/5/10 (late), 11/4/10 (late), 10/30/10 (late), 10/22/10 (late), 10/14/10 (late), and 10/13/10 (late) o Individual #39 on 12/28/10 (late), 11/16/10 (late), 10/25/10 (late), 10/20/10, 9/28/10, 9/8/10, 8/23/10, 8/16/10 o Individual #8 was restrained on 11/17/10 numerous times beginning at 4:36 am. He was taken to the emergency room at 6:00 am. There was no indication that the nurse assessed him prior to 6:00 am. On 11/10/10 at 1:10 am, a chemical restraint was administered. The nursing assessment indicated that the nurse was unable to assess at 9:00 am. There was no indication that a nursing assessment was attempted before that time. • Monitored and documented vital signs in 18 (45%). Vital signs were documented in 22 of the 29 (76%) of the records reviewed where the individual did not refuse assessment. Records that did not contain documentation of this included: o Individual #104 on 12/1/10, 10/30/10, 10/8/10, 10/21/10 (refused), 10/8/10, 8/6/10 (refused), 9/22/10 (refused), 12/23/10 (refused), 11/20/10 (refused), 11/5/10 (refused), 11/4/10 (refused) o Individual #13 on 10/22/10 (refused), 10/14/10 (refused), 10/13/10 (refused), 9/21/10 (refused) o Individual #39 on 12/28/10, 10/20/10, 9/28/10 (no times recorded), and 9/8/10 o Individual #8 on 11/17/10 and 11/10/10 o Individual #109 on 9/19/20 • Monitored and documented mental status in 30 (75%). Records that did not contain documentation of this included: o Individual #73 on 11/5/10 o Individual #104 on 11/5/10, 10/30/10, 10/8/10; o Individual #39 on 10/20/10, 9/28/10 (no times recorded), and 9/8/10 o Individual #8 on 11/17/10, 11/10/10 o Individual #109 on 9/19/20	

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		Based on documentation provided by the facility, no restraints had occurred off the grounds of the facility in the last six months. A sample of documentation for the last three dental restraints was reviewed. Based on a review of the last three pretreatment sedation dental restraint records there was documentation that the restraint was monitored by a licensed health care professional in all three records. Adequate monitoring did not occur for one individual. Individual #100 received dental pretreatment sedation on 11/29/10 at 11:30 am. The nurse assessed his vital signs and mental status at 11:30 am and 11:45 am. There was no evidence that the nurse conducted another assessment after the initial 15 minutes. The facility needs to develop a plan to ensure that monitoring and post restraint reviews are conducted as required and documented consistently. Restraints were not being assessed or monitored consistently as required by this provision. The facility was rated as being in noncompliance with this provision item.	
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	A sample of 40 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • In 32 (80%), continuous one-to-one supervision was indicated as having been provided. Five (13%) did not indicate level of supervision and three (8%) indicated routine supervision was provided during the restraint. • In 40 (100%), the date and time restraint was begun were indicated. • In 40 (100%), the location of the restraint was indicated. • In 14 (35%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. A majority of the restraint checklists described the behavior that was occurring, but did not indicate what events were occurring that might have led to the behavior. • Examples of inadequate documentation included: o The restraint checklist for Individual #109 dated 11/4/10 stated, “became aggressive towards staff” in the section describing events leading to the behavior, thus, offering no indication what might have precipitated this behavior. o The restraint checklist for Individual #104 dated 11/20/10 stated, “SIB, attacking staff” in the section describing events leading to the behavior. o The restraint checklist for Individual #13 stated, “became aggressive towards DCS attempting to punch” in the section describing events leading to the behavior.	Noncompliance

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	documented consistent with Appendix A.	• Some examples of better documentation of events leading up to the restraint included: o The restraint checklist dated 10/3/10 for Individual #13 described events leading up to the restraint incident with more detail. Staff stated, "He wanted staff to buy pizza. Staff told him that his dinner was in the kitchen if he wanted chicken. He said yes. Staff heated his meal and as soon as he walked into his room, he was throwing objects at staff." o The restraint checklist dated 11/5/10 for Individual #13 was also more descriptive in events leading to the restraint. Staff stated that "he attempted to go outside to patio area, door was locked; he became aggressive towards DCS by punching." • In 40 (100%), the specific reasons for the use of the restraint were indicated. Twenty-nine (73%) indicated that restraint was used due for both aggression toward staff and self-injurious behavior, eight (20%) indicated that restraint was used due to aggression towards staff, two (5%) indicated that restraint was used due to self-injurious behavior, and one (2%) indicated that restraint was used due to aggression toward peers. • In 37 (93%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. On three restraint checklists for Individual #104 (dated 10/8/10, 11/5/10, and 12/4/10), staff did not mark the type of restraint on the restraint checklist. • In 39 (98%), the names of staff who applied/administered the restraint was recorded. A restraint checklist dated 11/10/10 for Individual #8, did not indicated who had applied the restraint. Of the 39 that indicated which staff were involved, 11 (28%) identified the staff, but were not initialed by staff applying the restraint. • Observations of the individual and actions taken by staff while the individual was in restraint were recorded, including: o In 38 (95%), the observations were documented every 15 minutes and at release. The two exceptions were documentation for Individual #109 dated 9/19/10 and Individual #8 dated 11/10/10. o In 37(93%), the specific behaviors of the individual that required continuing restraint were recorded. • In 35 (88%), the level of supervision provided during the restraint episode was indicated. • In 34 (85%), the date and time the individual was released from restraint were indicated. • In 32 (80%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded.	

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		In a sample of 40 records (Sample #C.1), restraint debriefing forms had been completed for 39 (98%). A sample of three individuals subject to medical restraint was reviewed and in two (66%), there was evidence that the monitoring had been completed as required by the physician's order. Individual #100 received dental pretreatment sedation on 11/29/10. The restraint checklist indicated that he was only monitored for 45 minutes following the restraint. Sample #C.4 was selected using the list the facility provided of individuals who had received chemical restraint since the last onsite review. This included the following individuals: Individual #13, Individual #8, and Individual #109. This sample of three individuals who were the subject of a chemical restraint was reviewed. In five (100%) of five restraints, documentation indicated that prior to the administration of the chemical restraint, the psychologist was contacted to assess whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. As noted in the review of documentation above, the facility was not in compliance with the requirements of this provision item. The facility was not in compliance with this provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	According to EPPSSLC documentation, during the six-month period prior to the onsite review, a total of five individuals (Individual #39, Individual #13, Individual #109, Individual #104, and Individual #81) were placed in restraint more than three times in a rolling thirty-day period. All five of these individuals (100%) were reviewed to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed: • PBSPs and safety plans for all five individuals, functional assessment for Individual #81 (functional assessments for other individuals were not implemented, see K5), and personal support plan addendums (PSPA) for Individual #109, Individual #39, and Individual #13. The facility reported that they conducted PSPA meetings for all five individuals following the achievement of the above restraint criterion, however, only three PSPAs were located for this review. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. This item was rated as being in noncompliance because none of the PSPAs reviewed	Noncompliance

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		reflected an adequate review of the environmental, antecedent, and consequent variables that affected the behaviors that provoked restraint. It is recommended that the facility organize these PSPA meetings, and minutes, so as to ensure that each of the issues below are discussed and documented. Additionally, in order to achieve compliance with this item, EPSSLC needs to document that each individual's PBSP has been implemented with integrity, that specific procedures for training replacement behaviors have been developed, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	None (0%) of the three PSPAs' minutes reviewed reflected a discussion of the individuals' adaptive skills, or biological, medical, or psychosocial factors affecting the behaviors provoking restraints. For example, Individual #109's PSPA minutes stated that he was taking medications to address his medical problems, but how these medications potentially affected his physical aggression was not documented. Individual #109's medical condition may be an important precursor of the behavior provoking his restraint, however, it is important to include a discussion of how the medical condition potentially affects his aggression, and a recommendation to address the medical condition (e.g., a referral to a physician for evaluation and treatment of the medical condition) to prevent the probability of restraint in the future.	Noncompliance
	(b) review possibly contributing environmental conditions;	None of the PSPAs reviewed (0%) reflected a discussion of possible contributing environmental factors. Examples could include such things as noisy environments and suggestions for reducing noise to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For none of the three PSPAs reviewed (0%), were structural assessments of the behavior provoking restraints discussed. This item is concerned with a review of antecedents that may affect the behavior provoking restraints. One of the PSPAs reviewed (Individual #109's) briefly mentioned Individual #109 missing his home as a possible antecedent of physical aggression. The minutes did not, however, reflect a discussion of how staff should respond when they believe Individual #109 is missing family (e.g., phone calls) to decrease the likelihood that this antecedent will result in restraint in the future. There was no mention of antecedent conditions affecting the behaviors provoking restraint in the other two PSPA meeting minutes reviewed.	Noncompliance
	(d) review or perform functional assessments of the behavior	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. Possible functions of dangerous behavior that could	Noncompliance

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	provoking restraints;	be discussed here are escaping demands or accessing desired activities. This discussion should also include how these functions will be addressed to prevent restraints in the future. For example, if it is hypothesized that escape is maintaining physical aggression, then a discussion of how to ensure that physical aggression does not result in escape should be reflected in the PSPA minutes. None (0%) of the PSPA minutes reviewed reflected a discussion of the functions of the behavior provoking restraints.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All five individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. Of the five individuals in the sample who had PBSPs, the following was found: • Four (80%) specified the objectively defined behavior to be treated that led to the use of the restraint (Individual #104's definition of aggression was not operational; see K9); • Five (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (the specific method for teaching the alternative behaviors, however, was not present in any of the five plans); and • Five (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. None of those programs to weaken or reduce the behaviors that provoked restraint, however, were determined to be adequate because they did not contain clear, precise interventions based on a functional assessment (see K9). The Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In four out of five of the Safety Plans reviewed (80%), the type of restraint authorized was delineated (Individual #39's safety plan did not specify the type of personal restraint); • In three (60%) of the five safety plans reviewed, the maximum duration of restraint authorized was specified (maximum restraint duration was not include in Individual #81's or Individual #109's safety plans); • In five (100%), the designated approved restraint situation was specified; and • In five (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant	None of the individuals' (0%) behavioral data showed that the PBSP was implemented with a high level of treatment integrity (see K11 for more detailed discussion of treatment integrity at the facility).	Noncompliance

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	treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	There was no evidence in the PSPA minutes reviewed, or PBSPs of these five individual's, indicated, that any individual's PBSP was modified (when necessary) to decrease the future probability of an individual being restrained.	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.	Observation of the Daily Incident Management Team (DIMT) meeting confirmed that restraint incidents were reviewed by the team the following working day, but this review did not include an adequate assessment to determine the circumstances under which such restraints were used. Restraint incidents were reported to the DIMT and referred to the PST for follow-up. PSTs met following restraint incidents to review restraints, but as noted in section C7, supports and prevention strategies developed by teams were often not consistently implemented and revised when not effective. As noted throughout Section C, restraint documentation was often incomplete or inadequate for determining circumstances of the restraint. None (0%) of the Restraint Review forms in the sample indicated errors or incorrect procedures in documentation, application, or monitoring of the restraint. The section for recommendations for what might be tried to prevent restraint was not completed on any of the Review Forms. The facility needs to develop a review process that includes identifying problems with restraint application and monitoring procedures and developing a plan to address any deficiencies identified. Strategies to avoid restraints should be developed and monitored for effectiveness by PSTs following restraint incidents. The facility is not in compliance with this provision.	Noncompliance

Recommendations:

1. Behavior support plans should identify which behaviors indicate a true risk for potential harm to the individual or others and train support staff to recognize those behaviors.

2. The facility needs to look at engagement levels for individuals frequently restrained for self-injurious or aggressive behaviors and develop plans to increase engagement levels when indicated.

3. Ensure that all staff are trained on accurately completing restraint documentation.

4. The facility needs to develop a plan to ensure that monitoring and post restraint reviews of vital signs and mental status are conducted as required and documented consistently.

5. Include specific desensitization strategies in PSPs for individuals who require restraints for routine medical and dental appointments. Monitor and document progress on plans and modify plans as necessary.

6. Ensure that a restraint monitor is present within 15 minutes of the start of a restraint to assess the individual and monitor restraint application when necessary

7. When restraints are not applied, monitored, or documented correctly, the restraint monitor should include this information in the follow-up assessment. Develop a plan of correction to address any deficiencies noted in the review of restraints. Continue to monitor restraints and retrain staff as necessary.

8. Behavior support plans should be reviewed and revised when strategies are not effective for reducing the number of restraints implemented.

9. Ensure that psychology staff review restraint incidents and have the opportunity to make recommendations regarding interventions used in behavioral crisis.

10. Conduct and document reviews of individuals who have had more than three restraints in any rolling 30-day period as required by provision item C7.

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:** <u>Documents Reviewed</u>: o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o EPSSLC Policy: Protection from Harm – Abuse, Neglect, and Exploitation dated 8/26/10 o EPSSLC Policy: Level of Supervision revised 7/28/09 o Incident Management Committee meeting minutes for 10/1/10 – 12/1/10 o Sample of Video Surveillance Data Request o Three most recent five-day status reports o Minutes from 10/19/10 Interagency Meeting (DADS, OIG, and DFPS) o Training transcripts 25 employees, including the facility investigator o Acknowledgement of Obligation to Report Abuse form for 24 employees o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o List of Injuries by Individual since 1/1/10 o Client Injury Reports: • Individual #116, All injuries since 8/1/10 • Individual #15, All injuries since 8/1/10 • Individual #30, All injuries since 8/1/10 • Individual #90, All injuries since 8/1/10 o Log of all A/N/E allegations since 1/1/10 including case disposition Log of employees reassigned due to ANE allegations o Sample of notifications when an employee was released from reassignment due to allegations o PSPs for o Individual #58, Individual #89, Individual #100, Individual #79, Individual #132, Individual #195, Individual #93, Individual #1, Individual #109, and Individual #115 o Documentation from the following 24 completed investigations:

Case #	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
Sample D.1					
37065017	Neglect	Confirmed	7/18/10 7:52 pm	7/20/10 4:23 pm	7/28/10
37309020	Physical Abuse Neglect	Confirmed Confirmed	8/5/10 12:27 pm	8/6/10 11:54 am	8/15/10

37423240	Neglect Physical Abuse	Confirmed Inconclusive	8/12/10 8:08 pm	8/13/10 4:25pm	9/1/10 Extension requested
37789160	Neglect	Unconfirmed	9/5/10 8:20 am	9/5/10 10:20 am	9/11/10
37812943	Physical Abuse Neglect	Confirmed Confirmed	9/7/10 2:47 pm	9/8/10 1:15 pm	9/11/10
38119022	Physical Abuse	Unconfirmed	9/26/10 1:51 pm	9/26/10 3:49 pm	10/6/10
38272576	Neglect	Unconfirmed	10/6/10 6:19 pm	10/7/10 5:37 pm	10/8/10
38295779	Physical Abuse	Inconclusive	10/17/10 7:00 pm	10/17/10 7:30 pm	10/20/10
38303342	Physical Abuse	Unconfirmed	10/20/10 7:32 am	10/21/10 10:33 am	10/26/10
38313770	Neglect	Unconfirmed	10/22/10 11:25 pm	10/23/10 3:20 pm	10/27/10
38316446	Neglect (2) Physical Abuse	Confirmed Other	10/25/10 10:34 am	10/25/10 11:04 am	11/3/10
38323172	Neglect	Unconfirmed	10/27/10 3:39 am	10/27/10 10:35 am	11/3/10
38329575	Emotional Verbal Abuse	Confirmed	10/28/10 4:22 pm	10/28/10 5:40 pm	11/3/10
38333461	Neglect	Confirmed	10/30/10 4:34 am	10/31/10 2:30 pm	11/9/10
Sample D.2					
UIR 10-148 53686978	Neglect	Confirmed	8/1/10 7:55 pm	8/1/10 8:15 pm	11/4/10
UIR 10-154 54054638	Neglect	Confirmed	8/12/10 11:30 pm		10/13/10
UIR 11-001	Non serious Injury Undetermined Cause	n/a	9/1/10 10:40 am		10/18/10
UIR 11-007	Serious Injury Undetermined Cause	n/a	9/7/10 11:30 pm	9/1/10 11:45 am	9/17/10
UIR 11-009	Serious Injury Undetermined Cause	n/a	9/14/10 5:55 pm	9/14/10 6:30 pm	10/5/10
Sample D.3					
UIR 11-008	Death	n/a	9/12/10	9/12/10	9/22/10

			11:00 am	8:00 am	
UIR 11-041 56077988	Sexual Incident	n/a	12/5/10 8:15 am	12/5/10 8:20 am	12/14/10
UIR 11-045	Serious Injury Determined Cause	n/a	12/11/10 4:24 pm	12/11/10 4:35 pm	12/22/10

Interviews and Meetings Held:
- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Jaime Monardes, Facility Director
- Michael Reed, Lead Investigator
- Cynthia Martinez, QMRP Coordinator
- Gloria Loya, Human Rights Officer
- Valerie Grigg, Director of Behavioral Services
- Julie Norman, Training Specialist

Observations Conducted:
- Observations at all residences and day programs
- Daily Incident Management Review Team Meeting 1/4/11
- PSPA meeting for Individual #13

Facility Self-Assessment:

The facility POI indicated that EPSSLC was in substantial compliance with section D of the Settlement Agreement. The monitoring team found that while some areas of section D were in substantial compliance, there were a number of areas not in compliance particularly in regards to documentation.

Summary of Monitor's Assessment:

According to a summary of abuse, neglect, and exploitation trends for the previous two fiscal quarters provided to the monitoring team, investigation of 53 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 6/1/10 through 11/31/10. These 53 cases included 82 allegations involving 62 individuals identified as potential victims, and 32 staff at EPSSLC identified as possible perpetrators. Of these 82 allegations, 22 (27%) were confirmed by DFPS. Seven (9%) additional investigations were found to be inconclusive, indicating that there was not enough evidence available to determine whether or not abuse or neglect had occurred. The remainder of the cases included 21 (26%) unconfirmed cases, and 32 (39%) cases referred back to the facility. There had been a 14% decrease in the total number of allegations reported from FY10 4th quarter to FY11 1st quarter.

There were a total of 349 injuries reported at the facility for FY11 1st quarter. This was a decrease of 26% from the 4th quarter in FY10 and a decrease of 8% from the 1st quarter of FY10. Of the 349 injuries reported during FY11 1st quarter, six were considered serious injuries (2%), 237 (68%) were non-serious

	injuries requiring first aid, and 83 (24%) required no treatment. A concern related to the facility's commitment to ensure that abuse and neglect was not tolerated was the shortage of administrative staff assigned to incident management. The facility no longer had an incident management coordinator or support staff assigned to this activity. The lead investigator at the facility was assigned to all incident management duties and completed all investigations at the facility. Some of his duties included completing preliminary investigations and taking immediate action to ensure the individual's safety, coordination of investigations with outside agencies, review of all investigations, dissemination of recommendations for all incidents, follow-up on investigations, documentation and record keeping for investigations, data collection, and training all staff in abuse, neglect, and incident management procedures both initially and annually. Interviews with Michael Reed, the facility investigator, during the onsite monitoring visit and a review of documentation as indicated in section C, indicated that while the facility investigator was extremely knowledgeable and conscientious in handling investigations, he did not have sufficient time to complete all paperwork and follow-up on all investigations in a timely manner. As noted throughout section D, it was evident in a majority of incidents reviewed that appropriate action was taken to safeguard individuals at the facility when abuse and neglect issues were identified. There was concern, however, that the unmanageable work load assigned to this position would allow abuse and neglect issues to "slip through the cracks."

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated; and • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated the same commitment of zero tolerance. In practice, the facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples: • There were posters regarding this mandate posted throughout the facility. • Employees at EPSSLC were required to sign a form titled Acknowledgement of EPSSLC Employee Responsibility for Reporting Abuse/Neglect Incident(s) form annually. A sample of these forms was reviewed by the monitoring team for 24 employees. Current forms were in place for 22 of these 24 employees (92%). • In informal interviews throughout the facility, it was clear that staff had been trained on reporting abuse and neglect. When the monitoring team questioned staff regarding what action they would take if they witnessed or suspected abuse or neglect, all staff consistently stated that they report the incident to DFPS and to the facility director. • A refresher training class on abuse and neglect (ABU0100) was observed the week of the monitoring visit. The requirement to report suspected abuse and neglect was stressed by the trainer numerous times during the session. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 23 (96%) had completed the course ABU0100 in the past 12 months. It was evident that the facility stressed a zero tolerance policy for all employees at EPSSLC. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies,		

#	Provision	Assessment of Status	Compliance
	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.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy III.A.5, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS and the facility director. This was consistent with the requirements of the Settlement Agreement.
		
		With regard to serious incidents, the facility policy entitled Incident Management required that all serious incidents be reported to the facility director and included a reporting matrix that described incidents that were to be reported to DFPS within one hour if abuse or neglect was suspected, to DADS regulatory within 24 hours, and to DADS state office the next working day, if required. This policy was consistent with the requirements of the Settlement Agreement.
		
		According to data provided for the two quarters prior to the monitoring visit in the facility's quarterly trend reports for 6/1/10 – 11/30/10:
		• There were 53 DFPS investigations involving:
		  o Total abuse allegations – 22
		  o Total neglect allegations - 60, including:
		    ▪ Confirmed - 21
		    ▪ Unconfirmed - 20
		    ▪ Inconclusive - 7
		    ▪ Administrative Referral – 32
		    ▪ Pending – 1
		  (Note: Some investigations involved multiple allegations.)
		• Other serious incidents investigated by the facility included:
		  o Unauthorized Departures – 1
		  o Sexual Incidents – 4
		  o Deaths – 3
		  o Serious Injuries Determined Cause – 3
		  o Serious Injuries Undetermined Cause – 3
		
		Based on an interview of seven staff responsible for the provision of supports to individuals, seven (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.
		
		Based on an interview of seven staff responsible for the provision of supports to individuals, seven (100%) were able to describe the reporting procedures for other serious incidents.
			Noncompliance

#	Provision	Assessment of Status	Compliance

		Each home and day site had a poster entitled Quick Guide to Incident Management that directed staff on how to manage incidents by type.
		
		Two samples of investigations were selected for review. These included:
		• Sample #D.1 which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample.
		• Sample #D.2 which included a sample of facility investigations. Some of these were investigations that had been referred to the facility by DFPS, while others were investigations the facility completed related to serious incidents. See the list of documents reviewed for investigations included in this sample.
		
		In addition to the investigation reports contained in Sample #D.1 and Sample #D.2, additional incident reports were selected for review. Sample #D.3 was the sample of those additional serious incidents investigated by the facility.
		
		Based on a review of the 14 investigation reports included in Sample #D.1:
		• Fourteen (100%) of reports in the sample indicated that DFPS, the facility director or designee, and OIG or local law enforcement (when appropriate) were notified within the timeframes required by the facility policy.
		• As noted below, only two (14%) reports indicated when or if DADS regulatory or the state office was notified by the facility.
		• Two (14%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to all appropriate parties as required by facility policy. The following investigation files included evidence that DFPS, the facility director, and OIG or local law enforcement were notified as required: DFPS #38333461 and DFPS #38329575
		
		A standardized UIR which should have contained information about notifications was not included in investigation files in 13 out of 14 investigation files in Sample #D.1. DFPS case #38329575 did include a UIR completed by the facility.
		
		Based on a review of eight incident reports included in Sample #D.2 and Sample #D.3:
		• Four (50%) showed evidence that serious incidents were reported within the timeframes required by facility policy. Exceptions included:
		  o For UIR #10-148, the incident was reported at 8:15 pm on 8/1/10. The state office (SO) was notified at 12:42 pm on 8/2/10. Policy required notification to the SO by 9:00 am the following working day.
		  o For UIR #10-154, the incident was reported at 11:30 pm on 8/12/10.	

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		SO was notified at 1:30 pm on 8/13/10. Policy required notification to the SO by 9:00 am the following working day. o For UIR #11-007, the incident was reported at 11:30 pm on 9/7/10. SO was notified at 10:00 am on 9/8/10. Policy required notification to the SO by 9:00 am the following working day. o For UIR #11-008, the incident was reported at 11:00 am on 9/12/10. SO was notified at 10:00 am on 9/13/10. Policy required notification to the SO by 9:00 am the following working day. • Eight (100%) showed evidence that serious incidents were reported to the appropriate party as required by facility policy. The facility had a standardized reporting format. The facility used the Unusual Incident Report Form (UIR 12-17-09) designated by DADS for reporting all unusual incidents. This form was adequate for recording information on the incident, follow-up, and review. Based on a review of 24 investigation reports included in Sample #D.1, Sample #D.2, and Sample #D.3, nine (38%) contained a copy of the report utilizing the required standardized format. Documentation in the following cases in the sample included a standardized format: • DFPS case #38329575 (UIR#11-026), UIR #10-148, UIR #10-154, UIR #11-001, UIR #11-007, UIR #11-008, UIR #11-009, UIR #11-041 and UIR #11-045 Based on a review of eight incident reports included in Sample #D.2 and Sample #D.3: • Eight (100%) utilized the standardized reporting format • Eight (100%) were completed fully The facility was not in compliance with this item. Ensuring that a standardized report (UIR) is completed for each investigation will be necessary to comply with this provision.	
	(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	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy the facility was mandated to assure the safety and protection of individuals by immediately removing alleged perpetrators. Procedures for removing the alleged perpetrator were described in the policy in section X, titled Temporary Work Duty Reassignment of Alleged Perpetrators. Based on a review of 13 investigation reports included in Sample #D.1 and Sample #D.2, 13 (100%) of alleged perpetrators were removed from direct contact with individuals immediately following the facility being informed of the allegation when the AP was known. Three cases involved unknown perpetrators. For all cases reviewed, documentation was included in the facility file of a signed statement by the AP	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	acknowledging his or her reassignment on the day of the incident and included instructions prohibiting contact with individuals served by the facility. Based on a review of nine investigation files in which the AP was identified, a total of six (67%) showed that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation or the conclusion of the investigation allowed their return to direct contact duties (2), or the employee was not returned to the position due to the outcome of the case (4). The following cases are examples that showed documentation that the facility was in compliance with this provision: • In DFPS cases #37812943 and #37309020, the investigation file included documentation of the APs dismissal following DFPS's determination of confirmed abuse or neglect allegations. • In DFPS case #37065017, DFPS case #37423240, UIR #10-154, and UIR #10-148, the investigation file included evidence that the AP was not allowed to return to a position requiring contact with individuals until the case was completed and disciplinary action and/or retraining was completed. The following are some examples that did not document compliance with this provision: • The investigation file for DFPS case #37789160 indicated that the AP was removed from contact with individuals immediately. It did not indicate when the AP was allowed to return to her position. The neglect allegation was unconfirmed. • The investigation file for DFPS cases #38295770 and #38119022 documented removal of the AP from contact with individuals and retraining on abuse and neglect even though the allegation was unconfirmed. Documentation, however, did not indicate when the APs were allowed to return to their positions. • The investigation file for DFPS case #38303342 documented immediate removal of the employee from individual contact and documented retraining the employee to address concerns noted in the case. It did not indicate when the employee was allowed to return to his position as direct support staff. The facility did have a system in place for assuring that alleged perpetrators were not returned to regular duty until notification was made by the facility investigator. The process was reviewed during the onsite visit. A daily report of employees reassigned was sent to facility administrative staff by Hector Salazar, Human Resources Clerk. Emails concerning training required by employees prior to reinstatement were reviewed and indicated that Mr. Reed required proof of completed training when recommended	

#	Provision	Assessment of Status	Compliance
		before notifying Mr. Salazar to release the employee from reassignment Based on a review of the above documents, it was documented that adequate additional action was taken to protect individuals in 12 cases (86%). DFPS case #38316446 and DFPS case #38313770 did not document action that was taken to protect the victims. In all other cases in the sample, immediate action to protect the individual was documented in the investigation file. For example: • In DFPS case #37812943, there was documentation that showed the individual was checked for injuries by a facility nurse immediately following the incident. • In DFPS care #38119022, there was documentation of an immediate body check by a nurse and an emotional security check by psychology staff. • UIR #10-148 indicated that a physical assessment was completed by an RN, an emotional/security assessment was completed by psychology staff, and the campus administrator was notified to begin a preliminary investigation. • UIR #10-154 indicated that medical assessments were completed by nursing staff for the alleged victims and the habilitation director was notified for SLP follow-up regarding staff not following mealtime plans as noted in the investigation. The facility was not found to be in substantial compliance with this provision. Although, where documentation was available, it appeared that the facility acted quickly to put immediate protections in place, it will be necessary for the facility to ensure documentation of all action taken to protect the individuals involved.	
	(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 state policies required all staff to attend competency-base training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months, thereafter. This was consistent with the requirements of the Settlement Agreement. It further mandated that all supervisors must ensure that required training is appropriately documented by certification and date of completion as directed by the Health and Human Services Commission's Facility Support Services' Competency Training and Development Department. Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed. Not all training had been completed as required. A review of the training curricula related to abuse and neglect and incident management was reviewed for: (a) new employee orientation and (b) annual refresher training. The results of this review were as follows:	Noncompliance

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		• In relation to the requirement that training be competency-based, employees were required to determine whether or not mock scenarios were abuse or neglect and state steps that should be taken in each instance during the class. • The training did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. An ABU0100 class for new employees was observed during the monitoring visit. The agency investigator, Michael Reed, taught the class. Information was clearly stated, easy to understand, and supported the mandates included in the facility policy and section D of the Settlement Agreement. Review of 24 staff records (Sample #C.2), showed that; • 23 (96%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 21 (91%) of 23 employees with current training completed this training within 12 months of the date of previous training. • 11 (46%) of the 24 employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • Five (45%) of the 11 employees with current training completed this training within 12 months of the date of previous training. Based on interviews with eight staff: • Eight (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation. • Eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility needs to ensure that all employees receive annual training as required by the state policies on abuse and neglect and incident management. The facility was rated as being in noncompliance with this provision item.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy item II.B, all staff were required to sign a statement acknowledging zero tolerance for abuse, neglect, and exploitation of individuals and the obligations for reporting any suspected abuse, neglect, or exploitation during pre-service and every 12 months thereafter. A sample of 24 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 24, 22 (92%) had signed annual acknowledgments. One employee had a form that was signed, but not dated, so it is	Substantial Compliance

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	that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	unknown if it was signed annually as required. Another employee had a form that was last completed in 12/09. Training provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility was in substantial compliance with this item.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation section I.M, EPSSLC would maintain and provide a resource guide on recognizing and reporting signs of abuse, neglect and exploitation of individuals to the individuals, their primary correspondents, and their LAR. The resource guide would be provided to all new individuals upon admissions, and annually to the individual, LAR, and primary correspondents. A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. The guide was a clear easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. Based on a review of 10 individuals' PSPs (Sample #D.4), four individuals, or their LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. The six PSPs where this information was not found were new style format PSPS, including the PSPs for Individual #89, Individual #100, Individual #79, Individual #132, Individual #1, and Individual #109. The four "old style" PSPs in the sample contained documentation that this information had been shared with individuals and their LARs. The facility was not in compliance with this provision.	Noncompliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy section I.F, the facility would comply with this mandate by posting and supplying information on individual rights in a visibly, accessible area on each living unit and day program site. A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights,	Substantial Compliance

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		• information about how to exercise such rights, and • information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that 100% of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. An assistant ombudsman position had been created at the facility. There was also a rights officer position. Information was posted around campus identifying the rights officer. Documentation of investigations indicated that the rights officer was notified of allegations of abuse and neglect and reviewed completed investigations. The facility was attempting to develop a more active self-advocacy group on campus. Monitoring team members had the opportunity to attend a self-advocacy group meeting during the visit. See section E1 for more detail. The facility was rated as being in substantial compliance with this provision item.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy item IV.E, incidents were reportable to law enforcement. The policy mandated that the facility director or designee would immediately, within one hour, notify DFPS of any allegation that may involve criminal activity. DFPS was then responsible for notifying the appropriate law enforcement agency. Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications and the facility investigative file included information on the outcome of investigations by law enforcement. OIG provided the facility with a summary of their investigation and an email notifying the facility of the conclusion to their investigation. Based on a review of 14 allegation investigations completed by DFPS (Sample #D.1), in eight for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in eight (100%). The following are examples of allegations that were referred appropriately: • DFPS case #37789160 was referred to local law enforcement by DFPS within an hour. They declined to investigate the case. • In DFPS case #37423240, an allegation of physical abuse was referred to OIG for investigation by DFPS. • In DFPS case #38119022 an allegation of physical abuse was referred to OIG for	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		investigation by DFPS. The facility investigator reported that the facility had a cooperative working relationship with both OIG and local law enforcement. The facility is in substantial compliance with this item.	
	(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.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item IX, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. The policy included a list of phone numbers for the facility director, the Office of Attorney General, the Office of Inspector General, and DFPS to report any suspected retaliation. Based on interviews with the facility lead investigator, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ EPSSLC policy addressed this mandate. ▪ Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this it occurred. Additionally, there were posters in each residential and day site that provided reporting procedures for anyone that felt that he or she was being retaliated against for reporting. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were no concerns noted related to potential retaliation. Suspected abuse and neglect was immediately reported by employees when witnessed. The facility was in substantial compliance with this item.	Substantial compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Sample #D.2 included investigations completed on a sample of injuries. As noted throughout section D, these investigations were thorough and appeared to be routine. A sample of injury reports and supporting documentation was reviewed for all injuries since 8/1/10 for Individual #116, Individual #15, Individual #30, and Individual #90. The sample included a total of 16 discovered injuries. For each of the 16 (100%), the facility had conducted an investigation to try to determine the cause of the injury. Minutes from Incident Management Review Team meetings for 10/1/10-12/2/10 were reviewed and indicated that injuries of both known and unknown cause were reviewed the next working day following the injury or discovery of the injury. Follow-up on injuries was tracked in meeting minutes.	Substantial compliance

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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 EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy • described in a comprehensive fashion of the conduct of all such investigations in item V; • did not require that investigators be qualified as directed in state policy. The state policy required all facility investigators to complete the following courses: Comprehensive Investigator Training, People with MR, Conducting Serious Investigations or Fundamentals of Investigation, and a class in Root Cause Analysis. The EPSSLC policy did not address training in investigation techniques; • required that investigators have training in working with people with developmental disabilities, including persons with mental retardation in Item II; and • did not require that investigators be outside of the direct line of supervision of the alleged perpetrator. Training transcripts for DFPS investigators were not provided to the monitoring team for review as requested. All investigations in the sample were completed by Michael Reed, the facility investigator. Mr. Reed's training transcript was reviewed with the following results. • Completion of the requirements for investigations training, ICF1810: Conducting Thorough Investigations, INV0100: Fundamentals of Investigations • Completion of the requirements for training regarding individuals with developmental disabilities, MEM0300: People with Mental Retardation • He had not completed a course in Root Cause Analysis. Following the onsite review, the facility notified the monitoring team that he had completed this coursework in July 2010, however, no documentation was provided. This facility indicated that it will include this type of information in the documents it provides to the monitoring team during future onsite reviews.	Noncompliance

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		Additionally, 17 other administrative employees had completed CIT0100 Comprehensive Investigator training including the Campus Supervisors. These employees were able to begin preliminary investigations at the facility in the event that Mr. Reed was unavailable. The facility was not in compliance with this provision. The facility needs to update its policy to include state requirements for training of investigators.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Based on EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item IV, staff were required to cooperate with DFPS during investigations. The policy did not contain similar language addressing investigations conducted by OIG or local law enforcement. Review of the investigation files in Sample #D.1 showed that in 14 out of 14 investigations (100%), facility staff cooperated with DFPS investigators. Although OIG did not provide a detailed report to the facility, there was no indication that staff had not cooperated with OIG in investigations. Michael Reed, lead investigator, reported that the facility had a cooperative relationship with both DFPS and OIG. An interagency meeting was held on 10/19/10 with staff from EPSSLC, OIG, and DFPS to discuss the investigation process and responsibilities of each agency. Mr. Reed reported that the identified agencies would not be holding quarterly interagency meetings to discuss any problems found between the agencies. The facility will need to update their policy to include mandated cooperation of employees with all investigative agencies to ensure compliance with this item.	Noncompliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the facility, the following	Substantial Compliance

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		was found: • Of the 14 the investigation records from DFPS (Sample #D.1), eight had been referred to law enforcement agencies, including #37065017, #37309020, #37423240, #37789160, #38712943, #38119022, #38295770, and #38303342. For eight out of these eight (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • Of the eight investigation records from the facility (Sample #D.2), 0 had been referred to law enforcement agencies. The facility was found to be in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were mandated to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Exhibit B of the policy provided guidelines for the securing of evidence. In training observed for new employees, the safeguarding of evidence in an investigation was emphasized by the trainer. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • Evidence that needed to be safeguarded was in 0 out of 14 (0%) DFPS investigations, and • Evidence that needed to be safeguarded was in 0 out of 8 (0%) facility investigations. Video monitoring footage was provided to DFPS as requested. In two cases in the sample, DFPS case #37812943 and #37423240, video footage was available to quickly confirm the allegation.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants	The state policy Incident Management 002.2 mandated investigations of serious incidents: • were to commence within 24 hours or sooner, if necessary; • were to be completed within 10 calendar days of the incident; • did require a written extension request from the facility director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and • were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action.	Noncompliance

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	a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		• Ten out of 14 (71%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation.
		  o The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary DFPS Cases #37065017, #38303342, #38313770, and #38333461.
		  o Please note, however, that DFPS and the monitoring teams have discussed this issue and DFPS indicated that it planned to make the commencement of the investigation more explicit in the investigation report. In this way, actions taken by DFPS to commence an investigation will be clearly indicated.
		• Thirteen out of 14 (93%) were completed within ten calendar days of the incident, including sign-off by the supervisor.
		  o For the one that was not completed within ten days, there was documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension.
		• All 14 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement.
		• In all 14 (100%) of the investigations reviewed, recommendations for corrective action were included. In five of the investigations (37%), the recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations:
		  o For DFPS #37065017, the investigator addressed the concern that the individual did not have a recliner for repositioning as stated in his PNMP. He referred this concern back to the facility to address.
		  o For DPFS #37812943, the investigator included a recommendation to	

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		retrain staff on monitoring procedures to address a concern noted in the investigation. o For DFPS #38272576, the investigator included a recommendation to address staff not completing Client Injury Reports as required. The following were the investigations for which concerns were noted by the monitoring team with regard to the adequacy of the recommendations: o For DFPS case #37423240, the investigator found the allegation of neglect inconclusive, but noted that the PNM plan was not followed. There were no recommendations regarding this finding. o For DFPS case #38295779, witness statements raised concerns about staff shortages. The concern was not addressed. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: • Eight out of eight (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the facility being notified of the serious incident. Facility investigations began within minutes of notification in all eight cases reviewed • Four out of 8 (50%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; o UIR #10-154 was reported on 8/12/10. DFPS concluded its investigation on 8/19/10, referring the case back to the facility for investigation. The facility completed its investigation on 8/26/10. The facility director, however, did not sign off on the investigation until 10/20/10. o For UIR #10-148, the incident occurred on 8/1/10. DFPS completed its investigation with an inconclusive finding on 8/12/10. The facility investigator did not sign the written report until 11/4/10 and the facility director did not sign the report as reviewed until 12/3/10. o UIR #11-001 involved an injury of unknown cause reported on 9/1/10. It appeared that the investigation concluded on 9/4/10, but the investigator did not sign the report until 10/18/10 and the investigation was not reviewed by the facility director until 10/20/10. o UIR #11-009 was an investigation of an injury discovered on 9/14/10. The investigation was not completed until 10/5/10 and reviewed on 10/15/10 by the facility director. • All eight (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the	

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		basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • In eight of the investigations reviewed, recommendations for corrective action were included in seven of the investigations (86%). The recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations: o UIR #10-148 included recommendations for disciplinary action including performance counseling and retraining on abuse and neglect to address neglect allegations. o UIR #11-045 included a recommendation for the PST to meet to review the incident and continuing medical follow-ups until the injury healed. The following is an investigations for which the monitoring team had concerns with regard to the adequacy of the recommendations: o UIR #11-007 documented that video evidence indicated the individual was taken into his room at 1:02 pm and never exited the room thereafter until taken to the hospital late that evening. Concern that the individual had been left in his room all day was not noted in the investigation summary. The facility needs to ensure that documentation reflects the day that the investigation concluded and any documentation for any extensions requested in the case. The facility was not in compliance with this provision.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a	Based on a review of EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy Item VII.B did require that: • the contents of the investigation report be sufficient to provide a clear basis for its conclusion, and • the report utilize a standardized format that sets forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;	Noncompliance

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	recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	o The investigator's findings; and o The investigator's reasons for his/her conclusions. DFPS investigative reports in the sample were thorough, conclusions were well supported and documented, and appropriate recommendations were included. The only documentation that was found to not be routinely documented in DFPS reports was whether or not past allegations involving the AP or incidents involving the victim were considered in the evidence reviewed. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 14 out of 14 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately, the following: o In 14 (100%), each serious incident or allegations of wrongdoing; o In 14 (100%), the name(s) of all witnesses; o In 14 (100%), the name(s) of all alleged victims and perpetrators(when known); o In 14 (100%), the names of all persons interviewed during the investigation; o In 14 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 14 (100%), all documents reviewed during the investigation; o In 0 (0%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In 14 (100%), the investigator's findings; and o In 14 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • In eight out of eight investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.	

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		• The report utilized a standardized format that set forth explicitly and separately, the following: o In eight (100%), each serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of all alleged victims and perpetrators when known; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In eight (100%), all documents reviewed during the investigation; o In eight (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency o In eight (100%), the investigator's findings; and o In eight (100%), the investigator's reasons for his/her conclusions. As noted in D1, the facility had not completed UIRs on all DFPS investigations. To meet substantial compliance with this mandate, the facility needs to ensure UIRs are completed for all investigations, as well as the indication of use of prior history of individuals and staff. All UIRs that were completed by the facility were comprehensive in information regarding details of the investigation but as noted in D1, the facility had not completed UIRs on all DFPS investigations. To meet substantial compliance with this mandate, the facility needs to ensure UIRs are completed for all investigations, as well as indication of the consideration of prior history of all persons involved.	
	(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.	Based on review of EPSSLC Incident Management Policy at section V.E, the policy required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: (1) the investigation is complete; and (2) the report is accurate, complete and coherent. The policy required that the facility investigator must complete the Final Facility Investigation Report using the UIR format for each incident. This report is to be reviewed and approved by the facility director within five working days of the date the SSLC first learned of the incident (an exception is made for DFPS reports that are received within 10 calendar days from the date of initiation). The policy additionally stated that the IMC shall review all investigations including the written report, together with any other relevant documentation to ensure the investigation is thorough and complete and the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be	Noncompliance

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		addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 14 out of 14 investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. No deficiencies were noted in the sample of investigations reviewed. <u>Facility Investigations</u> In eight out of eight investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. No deficiencies were noted in the sample of investigations reviewed. As noted in the examples below, the review of the incident was not timely in all cases reviewed. There is some concern that deficiencies in the investigation would not be recognized in a timely manner to allow timely correction of problems. The following summarizes the results of the review of facility investigations where UIRs were available where there was a significant delay in review of the incident: • For UIR #11-009, dated 9/14/10, the investigator signed the report on 10/5/10. The facility director or designee did not review the report until 10 days later on 10/15/10 • For UIR #10-148 dated 8/1/10, the investigator did not sign the investigation review and approval until 11/4/10 and the facility director's designee did not review the final investigation until 12/3/10. • For UIR #10-154, dated 8/12/10, the investigation was completed on 8/26/10, but was not reviewed and approved by the facility director or his designee until 10/20/10. • For UIR #11-001, dated 9/1/10, the investigation appears to have been completed on 9/4/10, but the investigator did not review and approve the investigation until 10/18/10 and the facility director or designee did not sign the investigation until 10/20/10. The facility needs to ensure all investigations are promptly reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. The facility was not in compliance with this	

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		provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	As noted in previous in other areas of section D, the investigator had not completed UIRs for all abuse and neglect cases completed by DFPS.	Noncompliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy at VI. J, all recommendations and concerns documented in investigations must be reviewed and addressed by the facility director or designee within five working days. It further mandated that documentation of the recommendations and actions taken must be documented and maintained in the UIR file. The policy did not specifically state that disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. The policy did require that the facility was to have a system for tracking and documenting such actions and the corresponding outcomes. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2, and/or #D.3 was selected for review. This subsample, Sample #D.6, included the following investigations: UIR #10-154, DFPS cases #37812943, #38303342, #38295779, #37423240, #37309020, and #38316446. Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. The following summarizes the results of this review: • For three out of three of the investigations reviewed (100%), prompt and adequate disciplinary action had been taken and documented. For example, the following disciplinary actions had been taken: o In DFPS case #3782943, the incident occurred on 9/7/10, the investigation was completed on 9/11/10. The employee was notified of disciplinary action on 9/17/10 and was dismissed from employment on 9/23/10. o In DFPS case #37423240, the facility received the final investigation report on 9/2/10. On 9/13/10, the AP was sent a letter notifying him of the facility's decision to take disciplinary action for the confirmed allegation of neglect. He was suspended and required to complete retraining before returning to work. o In DFPS case #37309020, the facility received the final investigation on 9/1/10. Notice was mailed to the AP on 9/7/10 of the facility's intent to	Noncompliance

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		take disciplinary action. The employee was dismissed on 9/9/10. • For five out of five of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. For example, the following programmatic actions had been taken: o In DFPS case #3782943 completed on 9/11/10, the DFPS investigator recommended that additional staff in the home receive refresher training on levels of supervision. The investigation file showed follow-up by the facility investigator and notification by the training department indicated training was completed on 9/15/10. o In DFPS case #38303342, the allegation of neglect was unconfirmed. The investigator noted a concern regarding the approach the AP used in behavior intervention with the individual. The facility received the final determination and recommendations on 10/27/10 and the AP was retrained on the individual's BSP on 10/27/10. o In DFPS case #38316446, the allegation of neglect was confirmed against an unknown perpetrator. The DFPS investigator expressed concern in his findings over the lack of documentation on injuries. The facility retrained employees regarding documentation. o In DFPS case #38295779, the AP was required to complete retraining in Abuse and Neglect, Rights of Consumers, and Values: Making a Difference in People's Lives before returning to his position as direct support staff. The facility received the completed investigation on 10/21/10 and retraining occurred on 11/2/10. o For UIR #10-154, the investigator recommended retraining of staff on the importance of following diets and textures after individuals were given cookies that were not the texture recommended in their dining plan. The investigation concluded on 8/26/10 and staff was retrained on 8/26/10. The facility policy needs to be revised to include timeline for completing disciplinary and programmatic follow-up action upon completion of investigations. The facility was not in compliance with this provision.	
	(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	Based on review of EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, records of every investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the facility, investigation files were maintained in the investigator's office. Files requested during the monitoring visit were readily available for review at the time of	Substantial Compliance

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	particular staff member or individual.	request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.	
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 had a system in place to track data and trend information on unusual incidents and investigations. Data were compiled in a monthly and quarterly report with trends by: • Type of incident, • Staff alleged to have caused the incident, • Individuals directly involved, • Location of incident, • Date and time of incident, • Cause(s) of incident, and • Outcome of investigation. The facility compiled quarterly reports that focused on all unusual incidents, all allegations of abuse and neglect, and all injuries. Reports allowed for the examination of any trends that may be significant for further review. A narrative summary of the data was included in the report. The facility's Incident Management Review Team reviewed these reports to address any significant trends indentified. The monitoring team recommends that these data be incorporated into the facility's overall quality assurance program. The facility was in substantial compliance with this provision	Substantial Compliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks.	Substantial Compliance

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	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.	In concert with the DADS state office, the facility director had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 80 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the facility director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2010. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample of this signed form was requested for 10 current employees. Ten out of 10 (100%) had signed this form. In an interview with the facility director, he described action taken when applicants either reported or failed to report criminal offenses. The facility director made the final determination on continuation of employment, dependent on the outcome of a criminal investigation. His decisions were based on the facts and were mindful of his responsibility to safeguard the individuals and staff of the facility. The facility was in compliance with this provision of the Settlement Agreement.	

Recommendations:

1. Revise the abuse and neglect policy to include training requirements for staff assigned to complete investigations and incident reports.
2. Revise the abuse and neglect policy to include mandated cooperation of employees with all investigative agencies.
3. Ensure that all employees receive annual training as required by state policies on abuse and neglect and incident management.
4. Ensure standardized Unusual Incident Report forms are completed for all investigations, including those with completed DFPS investigations.

5. Include documentation in investigation files regarding steps that were taken to ensure alleged perpetrators were not reassigned to 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.

6. Develop a system to track and document the status of recommendations for corrective action made in completed investigation reports.

7. Revise the facility policy to include a timeline for completing disciplinary and programmatic follow-up action upon completion of investigations

8. Implement an audit process to ensure all serious injuries are investigated thoroughly and reported to DFPS if evidence does not fully support how the injury occurred.

9. Ensure investigation reports include a summary of the investigator's analysis of the history of the alleged victim and alleged perpetrator if relevant to the current investigation.

10. Ensure all investigations are reviewed by the facility director or designee within five days. Document and address any concerns if applicable.

11. Include evidence in PSPs that information on identifying and reporting abuse and neglect is shared with individuals and their LARs.

The following are offered as additional suggestions to the facility:

12. Facility management to review the workload of the facility investigator and determine if thorough investigation of all incidents is a reasonable expectation.

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 Review Processes, Quality Assurance Process, dated 6/28/10 o Organizational chart, not dated o EPSSLC policy list, two pages, not dated o List of typical meetings that occurred at EPSSLC o EPSSLC POI, December 2010 o EPSSLC QA Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/3/11 o A spreadsheet that was labeled "draft" that showed each Settlement Agreement provision, audit tools, sample size, audit frequency and other information o Set of 12 blank new nursing monitoring tools o Blank statewide Data Elements DADS submission form (two pages) o Table of different types of data divided into eight areas o Data collected by the QA department staff showing, in both spreadsheet and bar graph formats, since June 2010: • The data scores recorded by QA department staff • The reliability calculation when comparing the QA department's scoring with the scoring of the service department's staff (e.g., nursing) o Statewide trend analysis data and report for unusual incidents, abuse and neglect allegations, restraint usage, and injuries, fourth quarter FY10 (October 2010) o Completed set of DADS All Hazards Preparedness and Response Plan, completion date not provided o QAQI Council meeting minutes: 12/17/10, 11/5/10, 10/14/10, 9/30/10, 9/10/10 (five meetings) o QAQI Council meeting agenda for 1/5/11 o PIT meeting minutes, monthly 7/10 through 12/10 o DADS survey of staff engagement (satisfaction) for EPSSLC staff, February 2010 o Email from DADS Commissioner regarding follow-up to the statewide survey, 9/20/10 o EPSSLC family/LAR satisfaction survey description, statewide data through 12/1/10, and EPSSLC's specific responses (four) o EPSSLC CMS ICFMR review report, 6/8/10 o Self-advocacy meeting minutes, 8/10 and 9/10 o Self-advocacy meeting agenda for 1/5/11 Interviews and Meetings Held: o Jaime Monardes, Facility Director o Mary Stohr, Director of Quality Assurance

	○ DADS Central Office Staff: Michelle Martin, DADS Director of Quality Assurance; Linda Lothringer, Director, DADS Settlement Agreement Compliance Unit; and Rebecca Wilkins, Program Specialist, DADS Settlement Agreement Compliance Unit ○ Elaine Richter, RN, Petra Robledo, Victor Quiroz, EPSSLC QA department staff ○ Helen Alvarez, Settlement Agreement Coordinator ○ Gloria Loya, Human Rights Officer; Nora Padia, QMRP ○ Jeff Moody, Residential Unit Director ○ Lulu Contreras, Eddie Rodriguez, Advocacy, Inc. staff ○ Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: ○ Many residences, day program, and vocational program ○ QAQI Council Meeting, 1/5/11 ○ Self-advocacy meeting, 1/5/11
	Facility Self-Assessment: The facility completed its self-assessment for this provision, called the POI. The POI had been extensively revised since the last monitoring review as noted in the Monitor's executive summary above. The facility rated itself as being in noncompliance with all five items of this provision. The narrative portions of the POI, however, told very little about what facility staff were doing, or planning to do, to work towards substantial compliance. There was only one action plan and, although the items in the outcome box of the spreadsheet were relevant, they were too broad (i.e., expand databases, create reliable tools, identify action steps, develop a system to manage actions) and, therefore, the actions in the action step box of the spreadsheet were unlikely to achieve this outcome. More detail about accomplishing these types of outcomes is presented in the narrative of this section of the report. Thus, the POI was for section E was inadequate and provided little guidance and useful information to the QA department, facility management, and the monitoring team. In future POIs, more attention should be paid to creating measureable and obtainable actions and outcomes. In addition, the presentation book prepared by the facility for this section of the Settlement Agreement only contained photocopies of the DADS statewide policies. Although not a requirement of the Settlement Agreement or the monitoring team, the facility's intention was for the presentation books to be an easy way for the monitoring team to learn about progress and activities of the department in relation to this provision. Given the many upcoming changes to quality assurance practices that are anticipated to occur at EPSSLC over the next few months, it is hoped that the facility will engage in specific activities to self-assess the status of its performance for this provision and all of its components.

	The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the self-assessment's findings of noncompliance in all areas, except that the monitoring team noted highlights regarding some quality assurance-related activities that were occurring across the facility (e.g., data collection, assessment of inter-rater reliability). The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: EPSSLC was not in compliance with any of the items of this provision. The QA department had experienced a great deal of turnover since the last monitoring review. First, the previous QA director left the facility immediately following the onsite review six months ago and the new QA director did not begin until a month or so prior to this onsite review. Second, both of the QA program auditors left their positions a few months ago. Only one of the two positions had been filled. Fortunately, the QA nurse and the QA analyst remained since the previous review and they had continued to engage in QA-related activities, such as data collection, reliability assessments, data charting, and participation on various facility committees. Due largely to the recency of these staffing changes, the facility had made little progress towards achieving substantial compliance with this provision. There was no QA plan in place, the QA department did not maintain a listing of all data collected at the facility, a QA report did not exist, and data were not being used by senior management of the facility. The QAQI Council was only recently initiated, but had not yet been organized in a manner as directed by the DADS central office. More work will be needed to create guiding policy and procedures, a regular agenda, and a clear set of expectations for the council and its participants, including regular attendance and participation. The monitoring team, however, was impressed by the QA department's assessment of the reliability of the scoring of monitoring checklists used by the service departments at the facility. This was a regularly occurring activity and the QA department's data analyst regularly tabled and graphed the data. As discussed below in this section of the report, there were numerous aspects of data management that the department can consider as its moves forward in its collection and charting of this information. Some of the monitoring teams' checklist tools had been, or were being, modified by the facility to make them more user-friendly for facility staff and thereby more useful. This was good to see and the monitoring hopes this activity will continue for all areas of the Settlement Agreement. Corrective actions were not created or managed in any type of systematic way across the facility. Moreover, the relationship between the facility's single performance improvement team and the QAQIC needed to be clarified for members of both groups. Data from an employee satisfaction survey conducted a year ago were available to the facility, but had not

	been used. Recently (December 2010), the facility had begun to survey families and LARs about their opinions and satisfaction with services. The facility should be sure to use the information gathered from employee and family/LAR surveys in its QA department activities and in its senior management discussions. The self-advocacy group had been re-initiated and had met a few times since the previous monitoring review. The monitoring team attended a meeting during the week of the onsite review and also had the opportunity to speak with the facility's HRO who facilitated the meeting about ways to teach individuals the skills of decision-making and problem solving. Overall, the meetings appeared to touch on topics relevant to self-advocacy and the lives of the individuals (based on this observation and on a review of the minutes of previous meetings).

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	EPSSLC was without a director of quality assurance (QAD) from the time of the last monitoring review until only a month or so before this monitoring review. As a result, the facility had made little progress towards meeting the requirements of all items of provision E of the Settlement Agreement. Most of the comments provided in the last monitoring review report were still applicable at the time of this review. Moreover, both of the quality assurance department program auditors had resigned since the last monitoring review. Only one of those two positions had been filled (one remained open). The QA department nurse and the QA department data analyst were the only two staff who were the same as during the previous review. Even so, the quality assurance department continued to engage in numerous activities as described below (e.g., data collection, document reviews, interobserver agreement, data presentation, participation on various facility committees). EPSSLC was fortunate to have a dedicated QA nurse and QA data analyst who apparently led the activities of the department during the many months during which it had no one appointed as its director. This provision item was found to be in noncompliance due to the absence of an organized quality assurance program at EPSSLC. Immediately below are presented some main points regarding the monitoring team's observation of the QA program at EPSSLC. These comments are followed by a more detailed review of the QA program. First, again, a new Director of Quality Assurance was hired only a month or so prior to the onsite monitoring review. Second, a new Settlement Agreement Coordinator (SAC) was also recently appointed, in	Noncompliance

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		November 2010. The QAD and the SAC will need to work closely together regarding data collection and management. The monitoring team believes that these two new appointees will develop an effective and collaborative relationship, however, they will need guidance and supervision from the facility director to ensure that this occurs successfully. Third, the Quality Assurance and Quality Improvement Council (QAQIC) was formed in September 2010. Its sixth meeting was held during the week of the onsite review. The QAQIC is described below in section E2. Fourth, new policy revisions were being developed for the facilities by DADS central office. These had not yet been disseminated at the time of the onsite review. Fifth, the monitoring team had the opportunity during this onsite review to engage in an extended and interesting discussion with the QAD and staff from the DADS central office (participants are listed in the Interview and Meetings Held section at the beginning of this section of the report) regarding quality assurance, quality assurance plans, data collection, the profession of quality assurance (e.g., professional certification), and a variety of other topics related to quality assurance. The monitoring team greatly appreciated this opportunity and hopes that it was helpful to the state's ongoing development of quality assurance practices at all of the SSLCs. Moreover, the monitoring team remains open to participating in future discussions regarding quality assurance. Policies The Quality Assurance Director told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility (the facility had re-labeled the state policy as an EPSSLC policy). The facility also had an old document that attempted to describe QA processes. This document was not useful to the QA department and should be discarded. EPSSLC did not have any other policies related to quality assurance. The facility did not plan to develop any additional policies for quality assurance operations. The QAD was awaiting revisions to the state policy. A policy regarding the operation of the QAQIC, however, would likely be helpful to the operation of that committee as well as to the QA department (see section E2 below). Quality Assurance Plan The DADS policy required the development and implementation of a quality assurance plan (QA plan). Moreover, even if not required by state policy, a QA plan will increase the likelihood of the facility meeting the requirements of this provision. EPSSLC did not have a QA plan. The QAD gave the monitoring team a spreadsheet that	

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		was based on work at another SSLC. It listed out each of the provisions of the Settlement Agreement as well as the audit tool to be used, sample size, frequency of audit, and so forth. Although this may be helpful to the QA department, it was not a QA Plan. In general, a QA 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 may also include the types of data that should be submitted to the QA department from the various departments and divisions of the facility. It should also describe the type of report(s) to be generated. The QA plan should cover more than just the provisions of the Settlement Agreement. It should, for example, correspond to the many areas that should be under the purview of the both the QA department and the QAQIC (i.e., senior management), such as the areas described in a correspondence from the DADS Assistant Commissioner for the SSLCs and sent to the QA departments at all of the SSLCs: • Settlement Agreement compliance reviews, • DADS ICFMR reviews, • the facility's own mock ICFMR reviews, • Life Safety Code reviews, • the FSPI, and • All relevant quality assurance data from functional service areas of the facility. One other place to start is to create a listing of all data that are collected at the facility. The QAQIC could then look at this list and determine those data that it wished to regularly review at its semi-monthly meetings. The San Angelo SSLC had begun to embark on these actions and the EPSSLC QAD might benefit from contacting the San Angelo SSLC QAD. Again, there was no QA plan at EPSSLC and the absence of a plan should not be taken lightly by the facility. A plan needs to be developed. The facility and the QA department itself should view QA's role as being, in part, a repository for all data activities at the facility so that the information can be synthesized, summarized, analyzed, and presented to senior management (i.e., the QAQIC) in a manner that is useful for decision making and efficient and effective management of all services and supports at EPSSLC. QA Department As noted above, only two of the staff in the QA department remained the same since the previous monitoring review. The new director, Mary Stohr, was hired in December 2010 and supervised two QA program auditors (one was new, one position was vacant), the QA nurse, and the QA data analyst. Ms. Stohr had 18 years of experience in various	

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		positions at EPSSLC. At the time of this review, she also maintained responsibility for her previous position at the facility of risk manager. The intent was that a new risk manager would be hired and she would be relieved of these competing responsibilities. The facility director told the monitoring team that the QAD would be doing some mentoring with the QAD from another SSLC. This will likely be beneficial to her. In addition, the monitoring team strongly recommended that the QAD read, in detail, the quality assurance section (section E) of the previous two EPSSLC reports, as well as section E from the reports of the other four facilities reviewed by this monitoring team. Helen Alvarez, the Settlement Agreement Coordinator, was also new in her role. She will play a large role in the QA processes at the facility, too. Both the QAD and the SAC were professional and responsive to the many requests of the monitoring team during the weeks before, during, and following the onsite review. The monitoring team and the QA department (QAD, two program auditors, QA nurse, and QA data analyst) had a detailed meeting and discussion during the week of the onsite review. Topics included quality assurance (in general), data collection, handling and management of data, graphing, and inter-rater reliability. The monitoring team hopes that the QA department found this discussion to be useful (also see below). The QA department might also benefit from taking steps to more fully integrate into the overall operation of the facility. The monitoring team suggests that the QAD and SAC contact the QAD at the Lufkin SSLC regarding some of that facility's activities. These are also summarized in the October 2010 compliance monitoring report for Lufkin SSLC. <u>QA Activities and Indicators</u> Most of the tools described in the last monitoring review report continued to be implemented at EPSSLC. The facility was incorporating the use of the monitoring tools used by the monitoring teams, but more importantly, had revised some of those tools to be more appropriate and user-friendly for facility staff. The monitoring team believes that this was a statewide activity and that the intention was to eventually adapt or develop self-monitoring tools for all Settlement Agreement provisions that were based upon, but not identical to, the tools used by monitoring team members. The monitoring team recommends that the state continue this activity. The QA department staff collected a variety of data. Most of these were occurring during the baseline review and continued during the time of this onsite review. The monitoring team was impressed with the way the QA department staff had organized their activities, that is: a. the service department collected a variety of data (e.g., nursing, habilitation,	

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		psychology) b. a portion of those data were subject to facility's own self-monitoring by the service department staff (e.g., nurses, therapists, psychologists), c. a portion of the service department's self-monitoring was subjected to reliability assessment by QA staff. d. in addition, the QA staff collected some data on their own from around the facility. Thus, if the facility were to create a comprehensive list of the data collected at EPSSLC, it could contain four types of data, paralleling the above, as follows: a. all of the types of data collected by each service department b. all of the types of data (i.e., scores) collected by the service department's own implementation of the self-monitoring checklist tools c. reliability assessments done by the QA department d. additional types of data collected by the QA department. For nursing, for example, a variety of data were collected each month (e.g., frequency of various illnesses). In addition, there were now 12 self-monitoring tools that the nursing department used. The QA nurse conducted one reliability check of each of these 12 nursing self-monitoring tools each month. In addition, the QA nurse conducted reliability checks in other areas, too. The QA department's new program auditor was assigned six different areas as well as additional areas pending the filling of the vacant QA program auditor position. The data analyst managed the data collected by the QA department. He presented the monitoring team with the results of the QA department's data from implementation of 35 different monitoring checklist tools data across the facility. He did so in two graphic presentations. The first presentation showed the cumulative (since June 2010) scores recorded by the QA department for each of these 35 (range was 0% to 99%) presented in bar graph format. Also submitted to the monitoring team was a spreadsheet for each of these 35 showing the QA department staff member, date, and individuals sampled. The number of audits done since June 2010 ranged across these 35 checklists from one to 19. Some of these were multiple document audits done on the same day. The second presentation showed the percentage of agreement (i.e., inter-rater reliability) between the QA department's scoring and the scoring done by the service department's staff. These data were calculated for 31 of the 35 checklist tools and were also cumulative back to June 2010. Agreement percentages ranged from 0% to 100%. These percentages were put into a bar graph. It was good to see so much attention being paid to the assessment of inter-rater reliability of these QA practices.	

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		The QA department and the monitoring team had the opportunity to discuss their activities and data collection methods at length during the onsite review (as noted above). Three of the many topics discussed are described below. • The QA department could consider creating a criterion for reducing the frequency of reliability assessments, such as reducing the frequency from monthly to quarterly if three consecutive reliability assessments of 90% or better have been obtained. A criterion for increasing the frequency should also be considered, such as a score of less than 70%. • The data analyst suggested, and the QA department could consider, pulling out the service department's "no" ratings and providing the service department with this information so that it can be used for service improvements. Similarly, the data analyst could pull out "disagreements" in reliability assessment scoring between the service department and the QA staff so that discussion could ensue to determine the reasons for these disagreements. • We talked about the challenges in obtaining reliability assessments for outcomes that need to be directly observed (e.g., implementation of an instructional program) versus outcomes that only require the review of a completed document. As noted throughout this report as well as in the previous monitoring review report, many other staff (e.g., managers, clinicians, therapists) around the facility collected data for their own departmental operations and services. Most of these data were not part of the QA department. For example, below are other data, already collected at the facility, that might be incorporated into the EPSSLC QA program. • Set of nursing data collected by the nursing department, especially regarding the incidence of certain disorders and illnesses. • Set of data collected and managed by the medical department, including, for example, hospital admissions and discharges, ER visits, facility admissions, sick calls, labs, x-rays, and outside referrals. • Direct care staffing levels (also see comments made in the executive summary above). • FSPI. • DADS All Hazards Preparedness and Response Plan. • Data from the Admissions and Placement Coordinator and the Post Move Monitor (e.g., referrals, placements, obstacles to placement). • Assigned risk levels. In addition, the QA department might consider doing reliability assessments of the risk levels assigned to individuals. • The statewide trend analysis data (allegations of abuse and neglect, unusual	

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		incidents, injuries, and restraints). This was a set of data that DADS required be collected by every SSLC and submitted to DADS central office. These data, however, should be part of the overall QA program at EPSSLC. • The state data elements table (another set of facility data). These data were being reviewed by the facility's PIT. In addition, other areas noted in the baseline report, previous monitoring review report, or in discussions at the facility should be included in the QA program at EPSSLC. These include the following: • The four provision items of the Settlement Agreement that specifically refer to the need for quality assurance (F2g, L3, T1f, and V3). • Health Care Guidelines • Dental Guidelines • Staff satisfaction (see below) Comments made in the baseline report in section E1, under the heading QE Activities and Indicators, also continued to apply at the time of this onsite monitoring review, related to the reliability and validity of the QA process, however, as noted above, EPSSLC had made progress in its system of assessing reliability. In the baseline report and in the last monitoring review report, the monitoring team recommended that a variety of satisfaction measures be obtained as part of the QA system at EPSSLC. One measure should address staff satisfaction. A statewide staff satisfaction survey was conducted in February 2010 and the results were separated out for each facility. The survey was conducted by the University of Texas. It contained 71 standard items across a variety of work areas, as well as an additional 20 items specific to DADS facilities. The results provided relevant information that may be useful to the facility. More than half of the facility staff participated (247) and included many direct care non-supervisory staff. Two documents were available for review: one was an executive summary, the other provided the data for every question and presented the results in various formats. It did not appear that EPSSLC did anything with this information. Although the data were now a year old, the results may still be useful to facility management. For example, work climate and staff's perception of fairness of supervisors appeared to be two areas of concern identified in the report. During the onsite review at EPSSLC, the monitoring team was told that the facility did follow-up to any questions that were scored low, however, no evidence or examples were provided. The high rate of staff participation in the February 2010 survey may indicate that staff	

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		want to be involved and provide their opinions. Therefore, it may be possible to conduct a facility-specific follow-up survey or to engage in other activities to obtain staff input. One possibility might be to implement the suggestion box process that was in place at the Mexia SSLC. At that facility, written notes placed in suggestion boxes on campus were reviewed semi-monthly by senior management and follow-up, when appropriate, was coordinated by a member of the senior management team. In addition to the staff survey, DADS had initiated a survey of satisfaction of family members and LARs. The monitoring team was pleased to see this new activity. One-twelfth of the families and LARs were to be surveyed each month. Responses could occur via a paper format or via an online format. As of the week of the onsite review, 12 families/LARs were contacted and four had completed the survey (three on paper, one online). It was too early to make any findings, but there appeared to be some consistency across these first responses. The Admissions and Placement Coordinator was responsible for handling these surveys and their results at EPSSLC. The results (i.e., data) from the family/LAR surveys (as well as any staff surveys) should also be part of the facility's QA program. The monitoring team had the opportunity to meet the parent of one individual (Individual #164) during his CLDP meeting. She appeared to be very satisfied with services, except for the lack of training in communication and language skills. A measure to survey the satisfaction of related community agencies, providers, and vendors was not yet in place. The monitoring team continues to recommend doing so. As also noted in the previous monitoring review report, self-advocacy meetings present another way of obtaining information that may be useful to the QA department and facility management. It also can provide a context in which individuals can be taught group problem solving and decision-making skills. EPSSLC had initiated a self-advocacy group following the previous onsite monitoring review. Approximately 10 individuals attended each meeting. Minutes from previous meetings showed that the group discussed various relevant topics, such as "What does self-determination mean?" and "What kinds of things help you have control of your own life?" The monitoring team attended a meeting during the week of the onsite review. The president of the group was unable to attend, however, the facility's HRO and a QMRP facilitated the meeting (as they do each month). They began by reviewing some of the things they've talked about at previous meetings. Then, apparently based on previous meeting discussions, the group received a presentation by two staff from Advocacy, Inc. regarding community living. Then, the group engaged in an activity regarding "people in your life."	

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		At the conclusion of the meeting, the monitoring team spoke with the HRO about the group and their activities. One suggestion from the monitoring team was to work on the the teaching (and learning) of a structured group problem solving process, such as: • Define the problem in objective terms. • Generate two to four possible solutions. • Discuss the pros and cons of each solution. • Vote to choose a solution to implement. • Develop a plan to implement the solution. • Develop a plan to report on the results of implementation of the solution. QA-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, according to the QA director. The policy required a program improvement council; this was in place at EPSSLC and is described in section E2 below. It was changed to a new title, the QAQI council and it is likely the new policy for this area will describe the QAQI Council. QA Reports The DADS policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was not any type of performance improvement report at EPSSLC. The monitoring team believes that a QA report will help the facility to achieve substantial compliance with this provision.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in	This provision item required the facility to analyze the data collected by the QA processes that were 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. The facility's POI also indicated noncompliance. Further, the comments provided in the previous monitoring review report in section E2 continued to be relevant. 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. Performance Improvement Council and QAQI Council	Noncompliance

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	which each action step must occur.	The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Assurance. As noted above, the purpose of the meeting had changed at EPSSLC to have a facility-wide focus. This change had recently begun at EPSSLC and the group was called the Quality Assurance Quality Improvement Council (QAQIC). QAQIC minutes from the first four meetings were reviewed. The minutes indicated that each meeting was led by a different chairperson: the current facility director, the Assistant Director of Programs, the former Program Compliance Coordinator, and the former facility director. Not surprisingly, the minutes indicated some good discussion, but will not be consistent until the new facility director has the opportunity to hold a number of successive meetings. The monitoring team attended a QAQIC meeting during the week of the onsite review. It was led by the new facility director and lasted for 30 minutes. He planned to hold this meeting every two weeks. Attendance was sparse (e.g., no one from medical, psychiatry, pharmacy, or nursing). Attendance will need to be better if the group is to accomplish its goals. The topics discussed were about PST participation in the new risk assessment procedures, the consolidation of resources at the facility, the new active treatment action plan. The QAQIC did not review any data. Also, the QAQIC did not appear to be following the guidelines set by the DADS Assistant Commissioner for the SSLCs. CAPs, PITs, and PETs There was no organized system of generating, developing, disseminating, implementing, monitoring, documenting, modifying, or managing corrective action plans (CAPs) at EPSSLC. There was one Performance Improvement Team (PIT) at EPSSLC. It was, however, a group that reviewed the contents of the data elements chart. It was not a team charged with addressing a specific issue designated by the QAQIC. Based on a review of the PIT meeting minutes from the past six months, the group appeared to review a lot of data. The monitoring team expects that an organized system of managing corrective actions will be created and maintained in the future and be available for review for the next monitoring review. EPSSLC did not have any Performance Evaluation Teams (PET).	
E3	Disseminate corrective action plans	EPSSLC was not in compliance with this provision item.	Noncompliance

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	to all entities responsible for their implementation.	See comments above in section E2.	
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 new state policy when disseminated.

2. Consider whether the QA program would benefit from any facility-specific QA policies.

3. The new QAD should review section E of the previous monitoring reports for EPSSLC as well as for the other facilities monitored by this monitoring team.

4. Ensure that the work activities of the QAD and the SAC are coordinated.

5. Fill the vacant program auditor position; fill the vacant risk manager position.

6. Develop and implement the new QAQI Council process, including the development of policy and procedures, and the review and incorporation of the guidelines from the DADS Assistant Commissioner for SSLCs.

7. Create a facility QA plan that is functional, meaningful, and useful to EPSSLC managers, administrators, and clinicians regarding Settlement Agreement provisions and other areas of service provision. Consider the discussion above in section E1 as well as the following when designing a QA plan:
    a. List all data collected at the facility
    b. Include other data that should be, but are not, collected at the facility yet (see the four bulleted points in E1 above).
    c. Periodic review of the data list by the QAQIC
    d. QAQIC selection of data to review regularly
    e. Creation of corrective actions, when needed.

8. Continue to adapt the monitoring teams' checklist tools for use by the facility for all provisions of the Settlement Agreement.

9. Improve practices regarding reliability assessment and data management as noted by the three bullet points in E1 above.

10. Use the information gathered from the staff satisfaction survey and from the family/LAR satisfaction survey.

11. Collect data regarding the satisfaction of affiliated agencies and providers (e.g., a satisfaction survey).

12. Develop a QA report that includes a summary of all activities, data, trends, and narrative that describes important points about the data. See the description in section E2 above.

13. Develop a system to develop and manage corrective actions, following all requirements of provision items E1, E2, E3, E4, and E5.

The following are offered as additional suggestions to the facility:

14. Further develop the problem-solving component of the self-advocacy meeting as noted in section E1 above.

15. Take actions for the QA department to more fully integrate into the overall operation of the facility. The monitoring team suggests that the QAD and SAC contact the QAD at the Lufkin SSLC

16. Implement a procedure to obtain suggestions from staff members.

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 Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o EPSSLC Policy: Personal Support Plan Process dated 7/30/10 o Supporting Visions Training Curriculum o EPSSLC List of PSP development dates o The following documents for a sample of individuals: • Individual #90 – PSP dated 1/4/11 • Individual #31 – PSP dated 1/6/11 • Individual #89 – PSP dated 12/3/10 • Individual #100 – PSP dated 12/2/10 • Individual #79 – PSP dated 12/8/10 • Individual #132 – PSP dated 12/1/10 • Individual #103 – PSP dated 11/30/10 • Individual #1 – PSP dated 11/29/10 • Individual #109 – PSP dated 11/23/10 • Individual #73 – PSP dated 6/17/10, BSP • Individual #93 – PSP dated 10/6/10, PFW, Assessments, SPOs • Individual #115 – PSP dated 6/1/10, PFW, PSPAs, Assessments, SPOs • Individual #37 – PSP dated 6/1/10, PSPAs, SPOs, Assessments, PFW • Individual #110 – PSP dated 11/2/10, PFW, Assessments, SPOs • Individual #4 – PSP dated 7/13/10, Assessments, SPOs • Individual #88 – PSP dated 8/17/10, Assessments, SPOs, BSP • Individual #112 – PSP dated 12/15/09, BSP • Individual #111 – PSP dated 11/1/10, PFW, Assessments, SPOs • Individual #104 – PSP dated 6/10/10, PSPAs, Assessments, SPOs, BSP • Individual #195 – PFW, PSP dated 5/11/10, SPOs, Assessments • Individual #58 - PSP dated 10/14/10, PFW, Assessments, SPOs • Individual #60 – Draft PSP dated 1/5/11 Interviews Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Jaime Monardes, Facility Director o Cynthia Martinez, Interim QMRP Coordinator o Gloria Loya, Human Rights Officer

	o Valerie Grigg, Director of Behavioral Services o Julie Norton, Training Specialist <u>Observations Conducted</u>: o Observations at all residences and day programs o Daily Incident Management Review Team Meeting 1/4/11 o PSPA meeting for Individual #13 o Annual PSP meetings for: • Individual #60, Individual #31, Individual #90
	Facility Self-Assessment: The facility's POI indicated that the facility was not in compliance with most of the provision items in section F. The POI indicated that the new PSP process had been implemented in November 2010 and the facility would ensure compliance with this provision within 12 months of implementation of new procedures. 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 fully implemented. Some of the POI items were self-rated as being in substantial compliance particularly around the integration of assessments into the PSPs. As noted throughout section F, while the team did see progress in this area with the new style PSPs, plans still did not integrate all services and supports.
	Summary of Monitor's Assessment: Compliance with section F of the Settlement Agreement will require the facility to complete thorough assessments in a wide range of disciplines to determine what services are meaningful to each individual served and what supports are needed to allow each individual to fully participate in those services. Plans will need to be developed that offer clear directions for staff to provide supports deemed necessary through the assessment process and then a plan to monitor progress will need to be implemented so that plans can be updated and revised when outcomes are completed or strategies for implementation are not effective. Monitoring of plans will need to include a mechanism for ensuring that assessments are revised as an individual's health or behavioral status changes, and then outcomes and strategies will need to be revised in plans to incorporate any new recommendations from assessments. Finally, a service delivery system will need to be in place that addresses supports determined necessary by each PST. Administrative staff at EPSSLC had taken some small steps towards evaluating and revamping the service delivery system in regards to active treatment at the facility including: • All staff had been trained on the new statewide person centered process for developing PSPs. • Beginning implementation of the new statewide person centered planning process. • Identifying gaps in present programming and service delivery with input from multiple disciplines

	Although the facility was found to be out of compliance with the provisions in this section of the Settlement Agreement, it was promising to see that administrative staff was working to develop a plan to address gaps in service delivery. The DADS policy for this section had been revised and approved 7/30/10. The forms and instructions relative to PSP development had been revised prior to the monitoring team's visit. QMRPs had attended training on developing person centered plans and had begun to implement the new process at annual PST meetings. PST meetings observed the week of the monitoring visit were in the new-style format. For all QMRPs facilitating the meetings, this was a new process for them, as well as for other team members participating in the meetings. As expected, the meeting format was not completely comfortable for the QMRPs and the other team members. Discussion with QMRPs throughout the visit indicated that they were becoming more comfortable with the process, and other team members were learning how to contribute information at the meetings that would facilitate development of a plan that included supports necessary for individuals to achieve specific outcomes relevant to their preferences and identified needs. The monitoring team had the opportunity to observe three annual PST meetings during the review week. At PST meetings observed during the previous visit, meetings were formatted so that they began with each discipline present at the meeting presenting assessment results, then, almost as an afterthought, the team discussed the individual's preferences and vision for the future. During this visit, however, the format had noticeably changed. At the PSP meetings observed, team members were discussing supports needed in relation to the individual's preferences and interests. While this led to a more integrated plan, there was still not much progress made on identifying outcomes that would support movement towards living and working in a less restrictive environment. Quality Enhancement activities with regards to PSPs were in the initial stages of development. 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. A sample of 22 Personal Support Plans (PSPs) was reviewed. Nine of the plans in the sample were developed in the new style; the remainder was developed prior to implementation of the new PSP policies. The format of the plans indicated that there were some very positive changes occurring in PSP development that would lead to individuals having plans that were useful guides to staff supporting the individual on a daily basis. Information regarding supports that the individuals need throughout the day was more clearly stated in the newer PSPs. As noted throughout section F, while there was positive movement towards integrating supports throughout each individual's plan, there was not much progress being made on developing plans that would lead to a more meaning full day for individuals. Teams were restricted by the lack of program options offered at the facility and very little consideration was given to programming in the community. The state and the facility have acknowledged the failure of the previous PSP system to comply with the requirements of section F as evidenced by major revisions of policies and facility wide efforts at addressing

	PSP development, programming, and the integration of supports and services. Throughout section F, the monitoring team has focused on trying to provide the facility with examples of where, when applicable, changes have been effective in producing desired outcomes and examples of areas where problems have been identified and will need to be addressed as new procedures are developed. The monitoring team looks forward to seeing how systemic changes will impact specific outcomes for individuals once the facility has had a chance to implement these changes.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QMRPs at the facility were responsible for facilitating PST meetings, and for developing, monitoring, and revising treatments, services, and supports. All three PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings as required. A sample of PST attendance sheets were reviewed for presence of the QMRP at the annual PST meeting. At eight out of eight annual meetings, there was a QMRP present. As discussed in other sections of this report, it was not evident that assessments relevant to planning for each individual were being completed prior to PSP development, nor were plans or services consistently revised when not adequate or effective. See comments throughout this report regarding plan implementation, monitoring of plans, and revision of treatments, services, and supports. As a result, the facility was not in compliance with this provision item of the Settlement Agreement.	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.	Not all PSPs reviewed included sign in sheets that indicated who had attended and participated in the development of the PSPs reviewed. Of the new PSPs, eight (89%) of the nine had an attendance sheet attached. It was found that 0 out of eight individuals reviewed had appropriate team representation at the annual PST meeting. • Five (63%) of eight indicated that the individual attended the meeting; • Three (38%) of eight individuals had an LAR; two of these three (67%) were present at the annual PST. Staff present by discipline where relevant at the annual PST meeting included: • In eight (100%) of eight, the QMRP attended the meeting,	Noncompliance

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		• In five (63%) of eight, residential staff attended, • In seven (88%) of eight, day habilitation staff attended, • In one (50%) out of two, vocational staff attended, • In eight (100%) of eight, nursing staff attended, • In seven (88%) out eight, psychology staff attended, • In two (40%) out of five, the psychiatrist attended, and • In four (50%) of eight, appropriate PNM staff attended. The following are comments regarding participation in PST meetings for these eight individuals: • For Individual #90, there was a wide range of relevant disciplines in attendance and as a result, there was good discussion around supports that he needed in other areas of his life. The attendance sheet did not indicate that residential staff were in attendance at this meeting. • For Individual #132, there was no indication that he or his guardian attended his annual PST meeting. There also was no indication that there was input from the public school, though he was currently attending high school in the community. The psychiatrist was not in attendance at the meeting though he was taking Clonidine, Depakote, Trazadone, Risperdal, and Seroquel at the time of his PST meeting. • For Individual #103, the signature sheet from her PST meeting did not indicate that a physical therapist attended, though she has a wide range of adaptive and assistive equipment and specific plans in place for positioning, transfers, movement, and mobility. Additionally, there was not a communication therapist in attendance. She had significant communication support needs. Psychology did not attend her meeting though it was noted that she had a BSP in place to address hand-mouthing behavior that had resulted in hospitalization in the past. • There was no indication that Individual #89 attended his PST meeting. According to his PSP, his mother requested that he not attend his meeting. Communication staff was also not in attendance though he had communication strategies in place and utilized assistive technology to facilitate communication with others. Additionally, there were no physical or occupational therapists in attendance though he receives OT and PT and has one-to-one supervision due to his risk for falls. His job was listed as a priority for him, but vocational staff did not attend his meeting. Residential staff was not in attendance either. • The annual PST meeting observed for Individual #31 supported that the PST was comprised of an interdisciplinary team based on the individual's strengths, preferences and needs. • For Individual #100, the PST attendance sheet did not indicate that he attended his own annual meeting. There was not a communication therapist in	

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		attendance though he used assistive technology to communicate and had communication strategies in place. He received psychiatric services, but the psychiatrist was not in attendance at the meeting. • For Individual #1, the attendance sheet indicated that her advocate did not attend her annual meeting. There also was no OT, PT, or SLP in attendance though she was at high risk for falls, aspiration, skin breakdown, GERD, injury, bone fractures and swelling in her legs. She had a multitude of support needs around mobility, communication, positioning, and nutrition. • For Individual #109, the psychiatrist did not attend his meetings though he was at high risk for polypharmacy. He was taking Clonidine, Trazodone, Abilify, Lorazepam, Calmane, and Temazepam at the time of his PST meeting. He continued to need two-to-one staffing due to behavior problems and was reportedly having trouble sleeping. When key members of the PST are unable to attend meetings, it is suggested that the team documents any attempts to get input before the meeting and include recommendations from each team member who could not attend the individual's PSP meeting. The facility was rated as being out of compliance with this provision item.	
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.	The Personal Focus Worksheet (PFW) was the individualized assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. For the majority of plans reviewed, this list was individualized, fairly comprehensive, and offered a good starting point for plan development. Information gathered from the PFW was used as a basis for PSP development in the PST meetings observed. The QMRP reviewed the individual's list of preferences and members of the team contributed information on how this might be supported. This led to some great discussion and brainstorming by the team on ways to include each individual's preference into their day. Unfortunately, teams stopped short of looking at any real changes in the person's current living and work placement based on identified strengths preferences, and needs. Assessments for work and community living did not adequately address the lack of exposure to work and living opportunities. It is essential that assessments provide opportunities for individuals to participate in a variety of experiences relative to areas assessed. For example, vocational assessments tended to focus on how the individual performed on specific tasks available at the facility's sheltered workshop without regard as to whether or not the task was of interest to the particular individual. When performance was poor in that setting, it was determined that the individual did not have	Noncompliance

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		necessary skills to participate in supported employment. Vocational assessments should include situational assessment based on the individual's known skills and interests to determine if the individual is truly interested in possible work in an alternative setting. Some examples where adequate vocational assessments were not completed for the individual included: • For Individual #93, a vocational assessment was completed in September 2010. The assessment noted that she had very poor hand coordination, but the only trial task provided was to sort paper. The assessment noted that she appeared tired and distracted from the task. As a result, she was not recommended to participate in pre-vocational activities. Trial job task should focus on preferences and skills of the individual. • Individual #37 had a job in the community. His vocational assessment noted that he was employed in the community, but did not even state where he was working or what his job entailed, much less what supports he needed at his job. The quality of assessments is thoroughly discussed throughout this report. See sections H and M regarding medical and nursing assessments, section I regarding risk assessment, section J regarding psychiatric and neurological assessments, section K regarding psychological and behavioral assessments, sections O and P regarding PNM assessments, and section R regarding communication assessments. 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. Compliance will need to be demonstrated in these other areas regarding the development, monitoring, and revising of assessments in order to achieve compliance with section F1c.	
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.	A wide variety of assessments were performed prior to PSP development. The older PSP format included a summary of those assessments, while the newer PSPs showed an attempt to integrate the information into the plan where relevant. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed.	Noncompliance

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		PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, psychological, psychiatric, 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. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision. 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. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, it appeared that this information was not used to develop and implement protections, services, and supports for the individual. ▪ Individual #88 had a vocational assessment in June 2010. Her assessment noted that she was able to complete all contracts available at the workshop. Additionally, it noted that she showed pride in her work and enjoyed it. The assessment noted that she was a good candidate for supported employment. Her PSP included the desired outcome to continue attending the Workshop. There was no indication that the team was addressing supported employment. ▪ Individual #79 has a BSP in place to address aggressive behaviors, bizarre behaviors, and making false accusations. Her PSP did not indicate how these behaviors impacted her day or how staff should support her to minimize these behaviors. ▪ Individual #100 had a new style PSP that was a good example of a plan that integrated some assessment information into his plan and offered guidelines for supporting him and monitoring for risk. Medical and PNM assessments identified his risk associated with active seizures and brittle bones. The plan stated safeguards that were in place and how those risks were being addressed throughout his day. His PSP included a good discussion of his preferences, but not how those preferences would be incorporated into his day. His communication assessment indicated that he was nonverbal, yet communication strategies were not integrated into his plan other than to note that he used a communication book to express his wants and needs. ▪ Individual #12's assessment information concluded that he would be a good candidate for community placement. The only barrier to community placement was his guardian's objection to the move. His plan did not address how the team might educate his guardian regarding other living options. He enjoyed being out	

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		in the community and was working in community employment part time. The plan did not address additional integration into the community. The facility was not in compliance with this provision.	
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).	The new DADS policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual PSP meeting at minimum. In two of the annual PST meetings observed, the CLOIP MRA was the first to speak out against considering community placement. • In the annual PSP meeting for Individual #60, the CLOIP MRA, when asked about recommendations for community placement, stated "I don't think it would be good for her to leave because she requires a lot of care." Everyone on the team agreed, though some reluctantly. The QMRP suggested that she might like to visit some homes and noted that she was fairly healthy and liked to keep to herself which might make her a good candidate for community placement. Again, the MRA stated, "I don't think it's a good idea." When pressed to consider home visits, the MRA seemed at a loss as to how to arrange the visits. The CLOIP MRA did not appear to be familiar with supports that could be provided in the community. Her role should be to educate the team, whose members were also not familiar with possible community options. In the end, the team concluded that EPSSLC was the optimal living option for her. • For Individual #31, the team began the community options discussion very hesitant to recommend community placement, but as the team proceeded in the discussion, team members realized that community placement might be appropriate for the individual. The CLOIP MRA was not able to contribute suggestions to the team members on how they might approach exploration of community placement. The QMRP continued to encourage exploration of options for community placement and suggested that the individual should have the opportunity to visit other individuals that she knew that had moved into the community. The CLOIP MRA seemed hesitant to set up visits in a format other than the group visits that were currently being offered. The meeting concluded with the team agreeing to refer the individual for community placement since significant barriers to placement could not be identified. As evident by questions asked by the team regarding services in the community, the team seemed unsure of what real barriers to community placement might be. One team member asked if there were dental services in the community and another asked if two-to-one staff support could be provided for community outings. It is recommended that QMRPs seek additional information on what types of services and supports exist in community living options.	Noncompliance

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		PSPs indicated that community placement was discussed at all PST meetings. In most instances the teams concluded that current placement was optimal for each person. As discussed throughout this section, plans still did not always address priorities for work and community living. In seven (78%) of the nine new PSPs reviewed, the teams concluded that EPSSLC was the optimal living placement for the individual. All nine (100%) of the new style PSPs indicated that individuals and their LARs were offered information regarding community placement as required. There was no consideration of community-based day programs or supported employment by the team in PSPs reviewed. Although trips were planned in the community each week, there was limited focus on active treatment occurring in the community. • Individual #31's PFW indicated that trips into the community were a preference for her. Her SPOs did not address any functional learning in the community. Her community SPOs were to locate an EXIT sign and learn to adjust the radio. Training on these SPOs were to occur at the facility. • Individual #109's PSP included an objective to identify public places. Rather than supporting him to identify places while out in the community, his SPO was to identify public places with flash cards at the facility's day program. Similarly, he had a money skills objective that involved sitting at a table identifying a dollar bill from a picture. Both of these objectives could be more functionally taught in the community while on outings. • Individual #90 had an SPO to improve his community awareness skills. It stated that he would identify correct means of public transportation by pointing to the correct picture. This was not a functional community goal. • Individual #1's PSP did not include any information on activities that she enjoyed in the community or how she might be supported to engage in activities other than those provided at EPSSLC. There was no indication that employment outside of the facility had been actively pursued for any of the individuals in the sample except for Individual #37. It might benefit vocational staff at EPSSLC to attend updated job coach training to learn new skills for supporting individuals interested in obtaining supported employment. For additional comments regarding compliance with this provision, see section T. The facility was rated as being in noncompliance with this provision item.	

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F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The PSPs reviewed included a list of "What's most important to the person?" This was a fairly comprehensive list of the individual's preferences in the sample reviewed. For most individuals in the sample, this list was used as the basis for outcome development. As noted below, there were some exceptions to this, particularly around preferences for community participation and living options. It was not evident that this list was always the central focus in planning for the individual. Teams should use the "What's most important to the person?" section of the PSP to then develop outcomes, include supports that the individual needs to maintain or increase the occurrence of those things in his or her life, and to address any barriers to occurrence. PSPs did not consistently document why individual SPOs were chosen (also see section S1 below). For example for: • Individual #100, the team determined that his current placement at EPSSLC was the optimal placement though his plan stated that a quiet calm environment was a priority for him. It further noted, "however, at times that is not the case in his cottage." • Individual #31 had the outcome to "become more independent by gearing towards her favorite activity." One of the specific objectives to address this outcome was connecting the dots to complete her first name on a worksheet. It was not clear how this goal would help her achieve greater independence or how it related to her stated preferences. • See section F.1.e for additional examples. As also noted in section F.1.e, the PSPs did not address community integration and vocational programming. The facility had few options to address vocational services and discussion of real employment opportunities was not addressed in any of the PSPs reviewed. Individuals at the workshop should have been learning work skills that would transfer into employment skills for the community with the opportunity to make real	Noncompliance

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		wages in an integrated setting. Moreover, even though the facility's POI stated that programming was occurring in the community there was no indication or documentation of skill training in the community, except for one individual who worked four hours a week in the community (also see section S3 below). Another area of programming that EPSSLC needs to focus on is recreation and leisure activities available at the facility. Observations throughout the week of the monitoring visit indicated that there was very little engagement in interesting leisure or recreational activities in the evenings. It was noted that between 6:00 pm and 7:00 pm individuals had already eaten dinner and were getting ready for bed in all of the cottages except one where individuals had an outing scheduled. When individuals were engaged in activity, it was in activities that encouraged little communication and socialization opportunities such as working puzzles and watching television. There were not enough staff available in any of the cottages to allow for planned group activities. This would have been an ideal time to offer some leisure or recreation programs on campus that were in line with individuals preferences, age, skills, and interest. Perhaps recreation staff could develop a calendar of evening events to include activities such as arts and crafts, music, exercise classes, sports, and table games. Although, the monitoring team agrees that the facility needs to develop more meaningful programming options at the facility, the monitoring team would like to caution the facility that the expectation for this provision is that functional learning should also be taking place in the community. While it would be nice to see more activities offered as an option on campus, activities at EPSSLC should not take the place of activities that could be provided more naturally in community settings. For example, while recreation activities on campus are a great way to teach skills necessary for appropriate socialization and integration in the community, recreation in the community offers a better setting for learning integration skills in the community. PSPs reviewed were reflective of the lack of options and programming available at EPSSLC. PSPs did not address work and day programming in any detail other than to state the individual's interest. Barriers to participating in work activities were not addressed and meaningful supports and services were not put into place to encourage individuals to try new things. The facility was rated as being in noncompliance with this provision item.	
	2. Specifies individualized, observable and/or measurable goals/objectives,	As discussed in F2a1 above, outcomes were not always related to the individual's preferences and long-term vision, and plans were not consistent in addressing supports needed to achieve outcomes. Additionally, teams were not consistently identifying	Noncompliance

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	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;	measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Strategies included limited supports needed for implementation, but adequate supports were not always identified in assessment or, if they were identified, they were not included in planning. Some examples of outcomes and goals that were not measurable and/or did not include supports needed to accomplish the goal included: • Individual #79 had a goal to be offered the opportunity to participate in leisure activities of her choice before and after meals. It was not clear what skills would be gained from this goal or what staff needed to do to support her success in this goal. • Individual #88 had an outcome to improve personal hygiene skills that only involved staff prompting her to wipe after toileting. Data collection indicated whether or not staff prompted her, not whether or not she had completed the task. • Individual #88 had an outcome for leisure activities. The method stated that direct care staff would encourage her to choose an activity. Staff recorded data for when she was offered the activity regardless of her level of participation. Data collection did not allow for information to be gathered on her preferences, likes, and dislikes. • In one case there was a reference to communication outcomes an annual PSP Action Plan (Individual #93), but there were no measurable goals established and no evidence that a program had actually been implemented. Some examples of outcomes and goals that were measurable and/or did include supports needed to accomplish the goals included: • Individual #115 had an outcome for bathing. The outcome was measureable and included supports that he would need to complete the outcomes. Information on barriers and risks from assessments were included on the SPO. For example, the staff instructions noted that he should never be left in the shower area unattended due to his risk for seizures. Behaviors identified in his BSP that may interfere with implementation were also noted. • Individual #93 had an outcome for dressing skills. The training objective contained specific criteria for successful completion of the outcome. Communication strategies were included in the implementation plan. This provision will be further reviewed as applicable to the new person centered process	

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		during the next monitoring visit. The facility was rated as being in noncompliance with this provision item.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted throughout this report, many recommendations from assessments were not integrated into outcomes and strategies to support individuals throughout their day. PSPs developed using the new person centered training, however, showed progress in this area. Risk for individuals was not adequately identified and consistently addressed throughout the PSP to ensure that staff knew how to provide safe supports for each individual. See section I of this report for specific examples. When developing the PSP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. It is expected that full implementation of new state policies and training on person centered planning will guide QMRPs in developing more meaningful plans. This process will be further reviewed when the facility has had an opportunity to fully implement the new person centered planning process. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	A sample of 44 implementation plans for five individuals (Individual #115, Individual #88, Individual #4, Individual #104 and Individual #93) was reviewed. The following is a summary of what was found: • 39 (89%) out of 44 included methods for implementation. The following are some examples where SPOs included methods that would allow for consistent implementation: o Individual #115's SPO for bathing skills o Individual #88's SPO to trace her name The following are examples where SPOs did not include methods that would allow for consistent implementation: o Individual #88's SPO for budgeting o Individual #88's SPO for leisure activities • 44 (100%) out of 44 included time frames for completion, however, for 35 of these 44 (80%), the time frame was the annual PSP date rather than a date that corresponded with the individual's rate of learning. The team should assign	Noncompliance

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		completion dates that correspond with each individual's projected rate of learning. • 42 (95%) of 44 named the staff responsible for implementation. Individual #104 had two implementation plans that just stated "staff." See sections K and S for additional comments on implementation strategies. The facility was rated as being in noncompliance with this provision item.	
	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	As noted in previous sections, a majority of outcomes in the PSPs reviewed did not adequately address supports needed by the individual to achieve outcomes and did not consider what the individual would need to learn to become more independent in the community. As noted throughout this report, gaps in services available at the facility impacted whether or not needed services were addressed in PSPs. Further, it was not evident that community settings were always considered as an option for implementing outcomes. The facility was rated as being in noncompliance with this provision item.	Noncompliance
	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.	Implementation plans were not yet available for the newly developed PSPs. Current implementation plans were reviewed for a sample of the following individuals: Individual #115, Individual #104, Individual #4, Individual #88, and Individual #93. The following is a summary of this review. • 42 (95%) out of 44 identified the frequency of data collection • 43 (98%) out of 44 indentified the person responsible for data collection • 43 (98%) out of 44 identified the person responsible for data review All SPOs reviewed had a list of data codes that were to be used to indicate progress or lack of progress on implementation, but it was not clear what behavior the individual needed to demonstrate to receive a mark indicating successful achievement for the outcome. In the most recent set of SPOs in the sample (for Individual #93), implementation plans included specific data to be collected, but still did not describe what response would be considered a successful attempts. In the majority of plans, each SPO included a description of when outcomes should be implemented. SPOs named who would be responsible for implementation of each outcome, and indicated that the program developer would collect data and write a	Noncompliance

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		quarterly progress note and QMRP would monitor implementation. Please also see section S of this report for further discussion of SPO data collection. The facility was not in compliance with this provision of the settlement agreement.	
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.	This provision of the Settlement Agreement will also require compliance with several sections throughout this report including confirmation that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services as evidenced in sections J, K, M, O, P, R, and T. Please refer to these sections of the report regarding the coordination of services. The facility is encouraged to implement a monitoring process that reviews which services and supports are needed by an individual and assess whether or not those services are addressed in the PSP. While the monitoring team found a lack of coordinated supports and services throughout the facility, it was evident that the facility was attempting to ensure better coordination among disciplines. Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. As evidenced during observation of PST meetings at the facility, teams were engaged in more integrated discussions during team meetings. The monitoring team looks forward to seeing progress made at the next monitoring visit. 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. The facility was not rated as being in noncompliance with this provision item.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of 28 individual records was reviewed in various homes at the facility. Current PSPs were not available in eight (29%) of the 28 records, indicating that support staff did not have information necessary to fully implement PSPs. The facility needs to implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. As noted throughout this report, PSPs did not offer staff clear guidance on providing a range of supports to each individual to ensure training was consistently implemented and the person would remain safe and healthy.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. It was not evident that the facility had a system in place to monitor implementation monthly and revise the PSP when outcomes were completed or there was a lack of progress. It was also not evident that teams met when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate. As noted in F.2.a.6, plans identified staff responsible for monitoring implementation of each SPO. It was not, however, apparent that outcomes were monitored and revised as needed or that those who were responsible for monitoring plans were retraining staff on implementation if outcomes were not being implemented as written. For example, • Individual #115 had an SPO to identify a dentist and doctor. The instructions were to implement the goal every Friday. Implementation in June 2010 indicated that he had successfully completed the outcome 100% of the trials in 15/15 trials. In August 2010, he performed the task 54 times (typically twice daily) with a success rate of 42%. In September 2010 he attempted the task 44 times with a success rate of 25%. The progress notes indicated that the program developer had reviewed the data all three months, but there were no recommendations to address why the outcomes was not implemented as written or why progress on achievement of the outcomes was declining each successive month. • Individual #115 had an outcome to shave. Instructions indicated that implementation should take place every Friday. Documentation indicated that the outcome was implemented 38 times in June 2010, 48 times in July 2010, 22 times in August 2010, 17 times in September 2010, and 43 times in September 2010. If documentation was correct, he was often shaving twice daily. This does not seem likely, yet the program developer reviewed the data monthly and made no recommendations. • Individual #88 had an outcome to identify her right and left. Completion criteria was 95% for three reporting periods. According to documentation for the four months between July 2010 and October 2010, she had achieved 100% compliance all four months. The program developer had signed off on the data sheets each month, but did not indicate that the goal had been completed. • Individual #88 also had met the criteria for completing her money management outcome. The program developer, again, failed to revise the outcomes when it had been completed. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QMRPs need to keep in mind that PSPs should be a working document that will guide staff in providing supports to individuals with changing needs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Plans should be updated and modified as individuals gain skills or experience regression in any area. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP. The facility was not in compliance with this provision item.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	In order to meet the Settlement Agreement requirements with regard to competency based training, QMRPs will be required to demonstrate competency in meeting provisions addressing meeting facilitation and the development of a comprehensive PSP document. A review of training transcripts for 24 employees indicated that 24 (100%) of the 24 had completed the new training on PSP process entitled Supporting Visions. Of 18 training transcripts reviewed for direct care staff, all 18 (100%) had completed SPO Training Clients/Documenting (TRA0100). A sample of in-service sign in sheets was reviewed for six individuals in regards to individual specific training on the PSP. The signature sheets indicated that direct support staff received training on specific program objectives. There was no indication that training was competency based. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised. As noted in F.2.d, it was not evident that staff were being trained when plans were not implemented as written. The facility was rated as being in noncompliance with this provision item.	Noncompliance
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	Of PSPs in the sample reviewed, 22 of 22 (100%) had been developed within the past 365 days. A list of PSP dates for 134 individuals living at EPSSLC, however, indicated: • Only 1 of 134 (less than 1%) was not revised within 365 of the previous PSP • 52 of 134 (40%) were not completed and filed within 30 days of development • There were no individuals admitted to the facility within the review period As noted throughout this report, plans were not revised as needed. The facility was rated as being out of compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	extraordinary circumstances, the Facility Superintendent grants a written extension.		
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.	Quality enhancement activities with regards to PSPs were in the initial stages of development and implementation (also see section E above). 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. Develop a system to ensure that PSPs are in individual records and updated as necessary.

2. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed.

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

4. 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.

5. 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.

6. The team should assign completion dates that correspond with the individual's rate of learning and develop a set of next step objectives that will move the individual closer to his or her long-range goal.

7. Ensure that outcomes are consistently implemented and progress is documented and reviewed.

8. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.

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:** <u>Documents Reviewed</u>: o Organizational chart, not dated o EPSSLC policy list, two pages, not dated o List of typical meetings that occurred at EPSSLC o EPSSLC POI, December 2010 o EPSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 1/3/11 o List of clinical positions, staff and consultants o QAQI Council meeting minutes: 12/17/10, 11/5/10, 10/14/10, 9/30/10, 9/10/10 (five meetings) o QAQI Council meeting agenda for 1/5/11 <u>Interviews and Meetings Held</u>: o Jaime Monardes, Facility Director o Salvador Molina, DO, Medical Director o Jeff Moody, Residential Unit Directors o Helen Alvarez, Settlement Agreement Coordinator o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. <u>Observations Conducted</u>: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program o QAQI Council Meeting, 1/5/11
	Facility Self-Assessment: EPSSLC POI for G had both rated as being in substantial compliance. Although progress had been made, and examples were cited in the POI comments section, as well as in this report below, and more attention was being paid, there was not yet any criterion set, nor any guidance from state office. Further, additional work needed to be done. Therefore, the monitoring team did not agree with the facility's self-ratings for provision G.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite review to address this provision of

	the Settlement Agreement. The facility had identified the medical director as the lead manager for this provision of the Settlement Agreement, and a number of activities had occurred regarding this provision item since the previous review. Moreover, the medical director was knowledgeable about this provision and enthusiastic about the facility's ability to demonstrate integrated clinical care in the near future. A number of examples of ways in which EPSSLC was working towards a greater integration of clinical services, as well as examples of areas in which integration was not occurring, are presented below. It is suggested that all areas of clinical service provision, as specified in provision item G1, are included in the facility's provision of integrated clinical services. 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.	Although this provision was not yet in substantial compliance at EPSSLC, the monitoring team learned about, and observed, a number of efforts the facility had taken, and was planning to take, towards increasing the likelihood that integrated clinical services would be provided to individuals. Of particular note was the medical director's knowledge of the provision and his description of actions taken towards meeting substantial compliance with this provision. This was a great improvement from the previous onsite review. The monitoring team had the opportunity to talk with the medical director, Dr. Molina, numerous times during the week of the onsite review, including a discussion specifically regarding provisions G and H of the Settlement Agreement. An overall facility plan was not in place to address this item, and policies and procedures did not exist, though reports from DADS central office were that policies and procedures were in development to guide the facility. Policy might include specific examples of actions in which the facility should engage to set the occasion for the occurrence of integrated clinical services. More work needed to be done, as acknowledged by the facility by its medical director, and as described below. Consequently, this provision item is rated as being in noncompliance. Examples of integration of clinical services that were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • The medical director showed the monitoring team his personal log that documented a number of integration-related activities, such as:	Noncompliance

#	Provision	Assessment of Status	Compliance
		◦ a daily meeting with the new facility psychiatrist, to discuss and to resolve medical-psychiatry issues. ◦ a 12/15/10 meeting to discuss and review pretreatment sedation with the facility pharmacist and one of the nurse managers, and ◦ a meeting with facility administrative staff regarding preparation of the POI. • The medical director described the development of a clinical protocol regarding bowel management as an example of multidisciplinary activity at EPSSLC. He said that work towards developing this protocol set the occasion for cross discipline teamwork. He reported that participants included staff from the recreation department, PT, pharmacy, and residential direct care. • The medical directed led an interdisciplinary workgroup that developed several other clinical guidelines/protocols. • The medical director was a member of new committees on polypharmacy, P & T, and medication errors. • The medical department and pharmacy department communicated regularly, including, for example, a system for pharmacy reviews to be conducted upon physician request. • The new psychiatrist attended part of some of the PST meetings observed during week of the onsite review. • The consulting neurologist was to meet regularly with the medical director and psychiatrist. • It was reported that there was frequent contact between the dental hygienists and psychology staff in an effort to resolve the issue of refusals. ◦ Several emails were reviewed that indicated there were often discussions with QMRPs to this effect, too. • An example of integrated cross-discipline problem solving was work between nursing and recordkeeping to address the availability of information regarding recent seizure activity. This is described in more detail in section V1 below. • At a meeting to review risk levels for Individual #43 during the week of the onsite review, the medical director scheduled a subsequent meeting with the pharmacist, psychiatrist, consulting neurologist, and the individual's parent to further discussion seizure-related concerns. • Alex Euzarraga, QMRP, reported that staff from nursing, psychology, and skill acquisition program development attended an individual's IEP meeting at the local public school. • There was a committee at EPSSLC that looked at one-to-one staffing assignments. Staff from different facility departments participated, including the psychiatrist, residential unit director, director of behavioral services, human rights officer, QMRP coordinator, assistant director of programs, and the facility	

#	Provision	Assessment of Status	Compliance
		director. One example of an outcome that required integrated planning was to work towards having no more than three individuals per day receive pretreatment sedation in order to allow for residential managers to adequately provide the staffing needed for supervision of individuals following their medical appointments. Other examples indicated that more work needed to be done: • There was no participation of primary care medical staff at PST meetings. • Integration of clinical services was not evident in the written annual PSP document. The narrative should document the team's discussion and illustrate (a) how integration had occurred over the previous year and (b) plans to ensure integration of clinical care was to occur during the upcoming year. In addition, there will continue to be separate plans (e.g., PNMPs, BSPs, nursing care plans), however, the PSPs should identify (in action plans) the objectives of these separate plans, identify who is responsible for implementation, identify who will review data, any modifications of plans, and integration of these plans with other disciplines as appropriate. • During annual PSP meetings, there was no evidence that the individual's nurse provided a comprehensive overview of the individual's health status, needs, and risks, and/or informative descriptions of the individual's response to treatment interventions and their progress/lack of progress toward achievement of their desired health outcomes during the review period. • There were many examples of where speech and language staff and psychology staff did not work together regarding role of communication and behavior problems. • Due to the lack of integration among disciplines at the facility, it was difficult to assess if personal support plans, training objectives, and service objectives were carried out consistently as written. • There was a need for collaborative case formulation and diagnostics, as well as for the collaborative development of a behavioral/psychopharmacological treatment hypothesis. • The lack of meaningful integration of clinical services was evident in the absence of skill acquisition plans targeting communication and language programming. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. Under the leadership of the facility director, EPSSLC should address the need for integration of clinical services. Modifications to the PIC meeting into the QAQI Council may contribute to setting the occasion for this integration to occur.	

#	Provision	Assessment of Status	Compliance
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility appeared to be responsive to recommendations from non-facility clinicians. EPSSLC, however, should include in its operating procedures the requirement for an explicit statement, in the integrated progress notes, of the PCP's agreement or disagreement with each of these recommendations. The medical director reported that recommendations from non-facility clinicians were documented after individuals returned to the facility following hospital admissions and emergency room visits, but that this procedure was not yet in place for other non-facility clinicians who provided service and consultation to individuals. Record reviews indicated that physicians were reviewing consults and commenting on recommendations. These comments were usually noted on the consultation form. There was no process in place to determine in those recommendations agreed upon were actually implemented. The individuals' physician reviewed non-facility clinicians' reports and recommendations in a timely manner. In addition, he documented his review and medical plan of care in response to the clinicians' reports and recommendations in the individuals' records. The facility's Nurse Liaison position was vacant. Although it was reported that the nursing leadership team shared the responsibility of daily contact with non-facility clinicians regarding the status of the hospitalized individuals and their response to treatment, this was not evident during the review of 20 sample individuals' records noted in section M below. In addition, since the resignation of the Nurse Liaison, hospitalized individuals had not received face-to-face visits by members of the facility's nursing leadership team.	Noncompliance

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. Ensure explicit statement of agreement or disagreement with each recommendation from non-facility clinicians is included in the integrated progress notes.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Organizational chart, not dated o EPSSLC policy list, two pages, not dated o List of typical meetings that occurred at EPSSLC o EPSSLC POI, December 2010 o EPSSLC Sections G and H Settlement Agreement Presentation Books o Presentation materials from opening remarks made to the monitoring team, 1/3/11 o List of clinical positions, staff and consultants o QAQI Council meeting minutes: 12/17/10, 11/5/10, 10/14/10, 9/30/10, 9/10/10 (five meetings) o QAQI Council meeting agenda for 1/5/11 <u>Interviews and Meetings Held</u>: o Jaime Monardes, Facility Director o Salvador Molina, DO, Medical Director o Jeff Moody, Residential Unit Directors o Helen Alvarez, Settlement Agreement Coordinator o Alex Euzarraga, QMRP o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. <u>Observations Conducted</u>: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Many residences, day program o QAQI Council Meeting, 1/5/11
	Facility Self-Assessment: Facility POI indicated all seven provision items were not in compliance, and noted some comments regarding plans for additional hiring of clinicians, and need for policy to provide direction. The monitoring team concurred with these ratings as indicated below.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the onsite review to address this provision of the Settlement Agreement. Even so, some activities were occurring at EPSSLC.

	Similar to section G described above, medical and clinical staff were beginning to work towards meeting what they considered to be the criteria of this provision further highlighting the need for state policy to provide guidance and direction to the facility. 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. It is recommended that the facility's QA department play a role in addressing this provision.

#	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 The monitoring team had the opportunity to talk with the medical director, Dr. Molina, numerous times during the week of the onsite review, including a discussion specifically regarding provisions G and H of the Settlement Agreement. An overall facility plan was not in place to address provision H of the Settlement Agreement, and policies and procedures did not exist, though reports from DADS central office were that policies and procedures were in development to guide the facility. Policy might include specific examples of actions in which the facility should engage to meet each of the items of provision H. The medical director reported that sick call was done daily at his office as well as occasionally at the residences if needed. He also reported that medical annual and quarterly assessments were being completed and were likely to be up to date in the near future given the recent additions of a facility psychiatrist and advanced nurse practitioner staff. The monitoring team briefly reviewed the need for the psychiatry assessments to follow the Appendix B requirements of the Settlement Agreement. The records indicated that the medical staff responded to notification of problems by assessing the individuals and providing care. In addition to this, the medical director started to complete quarterly summaries that, in many instances, provided valuable information and detected unresolved issues. The annual medical summaries were being completed within timelines. At the direct service level, however, individuals' direct care staff members had not	Noncompliance

#	Provision	Assessment of Status	Compliance
		consistently notified the individuals' nurses in a timely manner of significant changes in the individuals' health status and needs. Once individuals' nurses were notified, however, they were "put on the clinic list" and their physician or nurse practitioner usually conducted a face-to-face evaluation within 24 hours or less, depending on the situation. Even so, there was a pattern of failure by the nursing department to ensure that emergent changes in individuals' health status, risks, and needs were identified, assessed, and addressed in a timely manner, reported to physicians, and closely monitored and evaluated until resolution (see section M below). There was also evidence of failure to ensure that ACPs were developed and implemented in a timely manner, and/or HMPs were reviewed and revised as significant changes occurred. At the time of this monitoring review, the facility psychiatrists had not begun comprehensive assessments per Appendix B. Furthermore, with regard to Health Status, the psychiatrist was not participating in all the PST meetings and will need to attend to discuss risks relative to polypharmacy and the effect of specific psychotropic medications on other health conditions. The facilities functional assessments (K5), PBSPs (K9), and psychological assessments (K5, K6, K7) were not consistent with generally accepted professional standards of care.	
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. EPSSLC was not tracking or monitoring this requirement. The medical director, however, reported that diagnoses were to fit assessments and that ICD diagnostic terminology was being used. A review of records indicated that this appeared to be the case. Eighteen of 20 individuals' nursing assessments, however, failed to result in a complete or accurate list of nursing diagnoses, in accordance with NANDA. For psychiatric diagnoses, this was not yet possible to determine. The treatment reviews by the new psychiatrist included DSM criteria resulting in the diagnosis of a specific disorder, however, evaluations as per Appendix B of the Settlement Agreement had not yet begun and will be reviewed during the next onsite review.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions	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 did not, at the time of this onsite review, have a way to manage this requirement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	shall be timely and clinically appropriate based upon assessments and diagnoses.	The medical director, however, reported that treatments were implemented timely, such as via follow-up on doctor's rounds, and telephone orders. A review of medical records also indicated that the medical staff were assessing individuals and providing the care they believed necessary based on the assessments. Across another 20 sample individuals (see section M), their physician and/or nurse practitioner prescribed treatments and interventions that were based upon timely assessments, diagnoses, and medical plans of care. In addition, they conducted follow-up until the medical problem was resolved. In over 80% of these records reviewed, however, nursing assessments were incomplete and/or failed to accurately portray the health status of the resident, including, but not limited to the severity of their high risk behaviors, self-injurious conduct, traumatic injuries sustained during behavior episodes, their heightened risk of infection due to other health risks, alteration in skin integrity, and non-adherence to clinical professionals' recommendations. There were also consistent failures to provide complete, accurate assessments of the individuals' responses to their treatment regimens, including, but not limited to evaluations of their responses to medications and treatments. Further, there was little to no justification of how, or whether, habilitative interventions were based on an analysis of data from the assessments. As it was difficult to determine the accuracy of psychiatric diagnoses, it was also difficult to determine the appropriateness of medication due to the paucity of psychiatric documentation. (see section J).	
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.	Some activity had occurred at EPSSLC regarding the determination of clinical indicators and appropriate clinical protocols. Most notable was the development of a number of protocols at the facility, such as for bowel management, diabetes, and coronary artery disease. Some of these were for facility-specific use, others were developed at EPSSLC as part of the statewide program to develop a set of clinical protocols for different medical conditions. The application of these clinical indicators were not yet being applied to service and treatment for individuals. 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, and they did not reflect the most current conditions and intervention strategies.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There were, generally, no measurable goals established for habilitation therapy interventions provided. Documentation was anecdotal in nature, making tracking progress, and comparing/contrasting data to determine progress over time difficult to do. 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.	
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 was rated as being in noncompliance. Development of state policy may help guide the facility in the determination of a system to effectively monitor the overall health status of individuals, not just their levels of risk. This might include a combination of a variety of information already collected by medical, nursing, pharmacy, and other departments at EPSSLC, such as the annual and quarterly medical assessments, nursing assessments, and pharmacy reviews. As noted in section I of this report, the facility (and state) system for assessing and managing risk was in the process of changing to a PST-based review of risk and health status.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	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
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 even though there were a variety of other healthcare-related policies and procedures in place at EPSSLC.	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. Involve the facility's QA department in the many monitoring and data tracking activities that will be required to increase the likelihood of meeting the requirements of this provision.

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 #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Risk Assessment Tools, dated 8/31/09 o DADS Integrated Risk Rating Form o DADS Quick Start for Risk Process dated 12/30/10 o DADS Risk Action Plan Form o DADS Risk Process Flow Chart o DADS Risk Guidelines date 12/20/10 o List of individuals with fractures or sutures/dermabond 10/1/09 – 10/31/10 o List of 10 individuals with the most injuries since 10/1/09-10/31/10 o List of 10 individuals causing the most injuries to peers since 10/1/09-10/31/10 o List of individual diagnosed with dysphagia and dining plans for those individuals o List of individuals with self-injurious behaviors o List of individuals at high risk for respiratory issues o List of individuals at high risk for choking o List of individuals diagnosed with GERD o List of individuals at high risk for aspiration o List of individuals that have contractures o List of individuals at high risk for skin integrity issues o List of individuals at high risk for impaction o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals at high risk for osteoporosis o List of individuals diagnosed with seizure disorders o List of individuals at high risk for seizures o List of individuals diagnosed with pneumonia since 2/17/10 o List of individuals with poor oral hygiene o List of individuals requiring meal time assistance o List of individuals at risk for weight loss or weight gain. o PSPs for: • Individual #90, Individual #31, Individual #89, Individual #100, Individual #79, Individual #132, Individual #103, Individual #1, Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Cynthia Martinez, Interim QMRP Coordinator

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- Salvador Molina, DO, Director of Physician Services

<u>Observations Conducted</u>:

- Observations at all residences and day programs
- Daily Incident Management Review Team Meeting 1/4/11
- PSPA meeting for Individual #13
- Annual PSP meeting for:
  - Individual #60, Individual #31, Individual #90
- Presentation by state and facility staff to the monitoring team regarding the new risk identification process and aspiration initiative

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Facility Self-Assessment:

The facility POI indicated that the facility was not in compliance with the provisions of section I. Notations in the POI indicated that the facility was waiting on the new state policy to begin implementation. The monitoring team agreed with the findings in the facility's POI for this provision.

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Summary of Monitor's Assessment:

The state had taken a number of steps to support positive results in the area of risk management. This included:

- The state policy addressing risk had been revised. It was approved 12/29/10 and implementation began the week of the monitoring visit at EPSSLC. The new policy included changes in evaluating and addressing risks indentified for individuals.
- Forms had been revised for identifying and a risk action plan to address risk had been developed.
- Risk Guidelines had been developed to be used by PSTs in rating risk factors.
- A new initiative was being implemented to address aspiration pneumonia. A tool had been developed to identify individuals at risk for aspiration.

The hope is that this process will more accurately describe risks for particular individuals and ensure services and supports necessary to protect each individual will be put into place.

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#	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	As required by state policy, a risk review at was being conducted at least every six months for each individual by the Health Status Team (HST) prior to 1/1/11. The new state policy, At Risk Individuals 006.1, required PSTs to meet to discuss risks for each individual at the facility. The facility was mandated to have its risk assessments/risk ratings using the new At Risk Process completed at each of the	Noncompliance

#	Provision	Assessment of Status	Compliance
	system to identify individuals whose health or well-being is at risk.	regularly scheduled next quarterly PST meeting held between 1/1/11 and 3/31/11. The at-risk process was to be incorporated into the PST meeting and the team was required to develop a plan to address risk at that time. During the week of the onsite review, the state coordinator of nursing services made an impromptu and very much appreciated presentation to the monitoring team about the new risk assessment policies and practices, schedule of roll out, expectations for facilities, and aspiration initiative. The plan included the state coordinators of nursing and habilitation therapies to visit each facility to do further training, including the direct observation of two annual PSP meetings. Immediate feedback would be provided to the facility management and QMRP. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and the behavior support committee. Special flow charts and instructional documents for staff regarding the focus upon aspiration and pneumonia were also shared with the monitoring team. A list of indicators for each of 21 risk areas had been identified by the new state policy and were to be rated according to how many risk indicators applied in each areas. The new policy had expanded the number of risk areas being addressed by this process to include choking, aspiration, respiratory compromise, weight, cardiac disease, circulatory, constipation/bowel obstruction, diabetes, gastrointestinal problems, osteoporosis, seizures, skin integrity, infections, polypharmacy, challenging behaviors, falls, fractures, fluid imbalance, hypothermia, urinary tract infections, and dental status. A risk level of high, moderate, or low was to be assigned for each category. Observation of three annual PSP meetings scheduled the week of the review showed that PSTs had not yet begun this new process. The nine new style PSPS developed using the new person centered planning process was reviewed to determine if risk were being properly identified by PSTs. Six of these nine occurred prior to 1/1/11 and, therefore, the new risk assessment procedures were not yet required. As noted immediately above, the three PSPs that occurred after 1/1/11 (during the week of the onsite review) also did not yet incorporate the new risk assessment procedures. Even so, the following comments may be useful to the facility as it begins initiation of the new risk assessment procedures. • Individual #100's PSP provided a good example of where risks were identified and supports needed were summarized in his plan. The PSP identified that he was at risk for seizures, choking, aspiration, GERD, osteoporosis, falls, and challenging behaviors. Supports needed to safeguard him were described for each of the risks identified. • Individual #90's PSP indicated that he was at risk for self-injurious behaviors, falling, fractures due to brittle bones, choking, and aspiration. The PSP	

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		described safeguards that staff should follow to protect him from injury. He was included on the list of individuals with poor dental hygiene, but this was not noted in his PSP. He was not included on the list of individuals at high risk for falls or injuries though his PSP did indicate that he was at high risk. • Individual #31's PSP indicated that she was at risk for self injurious behaviors and aggression and listed triggers for these behaviors. It also noted that she was at risk for choking and weight gain. Her PSP indicated that she was on a modified diet to address these risks. She was included on the list of individuals with poor dental hygiene, but this was not noted in her PSP. She did not appear on the facility list as high risk for choking. • Individual #89's PSP indicated that he was at risk for falling and required one-to-one supervision when ambulating outside and when bathing to protect him from possible injury. He was on a chopped diet due to his risk for choking and aspiration. Precautions were listed in his PSP due to his risk for reflux. According to his PSP, he was at risk for challenging behaviors and on multiple medications to address his behaviors. He received psychiatric services and medication reviews and had a BSP in place to address behaviors. He did not appear on the facility list for choking or aspiration. • Individual #79 was identified as being high risk for weight issues. She was on a modified diet described in her plan. She was also at risk for GERD. The plan described "GERD precautions" that staff should follow. Other diagnoses that were included in her plan were hypertension, constipation, seizure disorder, and hypertriglyceridemia. Her plan noted that these were being monitored by medical staff. • Individual #132's PSP indicated that he was at risk for choking and had a modified textured diet to address this risk. He was also at risk for challenging behaviors and had a BSP in place to address targeted behaviors. He was on multiple psychotropic medications that were being monitored by the psychiatrist. • The PSP for Individual #103 indicated that she was at risk for skin breakdown, reflux, UTIs, fractures, and aspiration. The PSP did not describe supports necessary to safeguard her throughout her day. • Individual #1's PSP indicated that she was at risk for seizures, skin breakdown, falls, aspiration, fractures, reflux, injury, constipation, and osteoporosis. Her PSP indicated that her PNMP plan would address these risks. There was limited information in her PST regarding how support staff should address these risks throughout her day. Her dining plan simply stated "she was to remain in upright position 30 to 45 minutes during and after meals/G-tube diet/feeding, medication passes and/or oral care activities." No further instructions were offered as far as correct positioning or monitoring mealtime. She was included	

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		on the list of individuals at high risk for aspiration, choking, and seizures. She was also on the list of individuals with the highest number of injuries at EPSSSLC. She had 32 injuries between 10/1/09 and 10/31/10. There was no discussion of this in her PSP. • Individual #109's PSP indicated that he was at risk for choking and on a chopped food textured diet. He also had a history of seizures that were controlled by medication. He took multiple medications and was at risk of polypharmacy. His plan noted that he would receive psychiatric follow-up and monitoring. He was at risk for challenging behaviors and these were described in his PSP. He was included on the high risk list for dysphagia and contractures provided by the facility. Contractures were not addressed in his PSP. • Additional examples are detailed in sections M5 and O2 of this report. The facility was not yet in compliance with this provision of the Settlement Agreement, but it was noted that they were attempting to address this provision and put safeguards in place for individuals at the facility. It is expected that all individuals at EPSSLC will have gone through the new risk identification process by the time of the next monitoring visit.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The new At Risk policy required that when an individual was identified at risk, the PNMT or BSC begin an assessment within five working days. The PNMT or BSC was required to assess, analyze results, and propose a plan for presentation to the PST within 14 working days of the completion of the plan, or sooner if indicated by risk status. As noted in section I1 above, not all risks were identified by the PST. In addition, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Even so, there were examples of cases where once it was identified that an individual suffered a significant change in one of more of his or her "at-risk" conditions, mini-staffing meetings (PSPAs) were convened in a timely manner and nurse case managers consistently attended and participated in these meetings. Further, the new procedures of referral to PNMT or BSC were not yet in operation. Further, the development of clinical pathway protocols, as mentioned in sections G, H, and L of this report, will inform the PSTs and nursing and medical staffs regarding assessment of whether appropriate protocols are, or are not, in place for the individual to address each of his or her risk areas. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels be assigned cautiously to ensure proactive	Noncompliance

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		measures are taken to monitor each individual's health and safety. One of the most important aspects of a health risk assessment process is that it effectively prevent the preventable and reduce the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk and proper assignment of level of risk. The facility was not yet in compliance with this provision item.	
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. It required that the PST implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the PSPs that were reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Some identified risks had no individualized plans developed to address them. Rarely were all the relevant clinical indicators to be monitored, and the monitoring frequency, clearly specified in individuals' PSPs or Health Management Plans (HMPs). See sections M1 and M3 of this report for examples. The new policy requires that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the PST in response to risk categories identified by the team. Although PSPs included a number of plans to address risk identified by the PST, during observations of homes by the monitoring team, it was noted that PSPs were often missing from individual records, so direct support staff did not have current information regarding risks available to them. As noted in section F of this report, a sample of 28 individual records was reviewed in various homes at the facility. Current PSPs were not available in eight (29%) of the 28 records. If there is not a current PSP in the home, staff do not have the information that they need to provide safe supports and services to individuals in the home. Staff cannot be held responsible for implementing a plan that they do not have. The facility needs to implement a monitoring system to ensure that staff have information readily available at all times to provide necessary supports to each individual in the home. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk. The facility was not in compliance with this provision item.	Noncompliance

Recommendations:

1. Implement the state new policies and procedures on at risk individuals.

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

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. Implement a monitoring system to ensure that direct support staff have PSPs and other plans readily available at all times to provide necessary supports to each individual in the home.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Policies, procedures, and/or other documents addressing the use of pretreatment sedation medication. o List of individuals who received pretreatment 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 is in place to minimize the need for the use of pretreatment sedation medication. o Any auditing monitoring data and/or reports addressing the use of pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols. o A spreadsheet of individuals prescribed psychotropic/psychiatric medication, listing name of individual, residence/home diagnoses, and medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration). o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use. o A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date. o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o A list of individuals being monitored for tardive dyskinesia. o A list of individuals with tardive dyskinesia. o A separate list of individuals being prescribed: • Anti-epileptic medication being used as a psychotropic medication, Lithium, Tricyclic antidepressants, Trazodone, Beta blockers being used as a psychotropic medication, Clozaril/clozapine, Mellaril, Serentil o List of new admissions since 1/1/10, and whether a Reiss scale was used. o List of new admissions since 1/1/10 and whether a Reiss scale was used. o For five individuals most recently admitted, and for the seven other individuals • Their most recent psychiatric assessment; • Last three psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other team members; and • For the past year, Dates of all Psychiatric Treatment Reviews, Health Services Team notes, MOSES and DISCUS exams, Neurology consults (if any); and The most recent Medical, Pharmacy, and Nursing summaries.

	• Across these individuals, at least one individual from each psychiatrist's caseload. o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations. o Description of availability of genetic screening for individuals. 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, such as AIMS, MOSES, and DISCUS. o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o Job description of psychiatrists. o A list of all psychiatrists, including board status, whether employed or contracted, and number of hours worked each week. o Example of contract with contracted psychiatrists. o CVs of all psychiatrists, including any special training such as forensics and disabilities o Overview of psychiatrists' weekly schedule. o Over the past 12 month, a list of continuing medical education activities attended by medical and psychiatry staff. o Academic affiliations with educational institutions. 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, and • 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). Documents Requested Onsite: o Pharmacy and therapeutics meeting minutes for the six months prior to the monitoring review o Five medical and five dental desensitization plans o Dr. Chavez-Rice's documentation regarding dental pretreatment sedation (up to 10 examples) o Information regarding chemical restraint for the past three months: individuals name, date of medication administration, medication/dosage/route of administration, reason for the restraint. o Information regarding the lack of Reiss Screen for Individual #144 o Ten examples of Dr. Chavez-Rice's treatment/diagnostic concordance documentation. o Five examples of psychiatric evaluations performed per Appendix B o All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 1/4/11 regarding Individual #66 and Individual #112 o Documentation from the emergency PST meeting dated 1/4/11 regarding Individual #37 o Tracking data for psychiatry attendance in PSP, PSPA, and PST meetings for the past two months

	- All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 1/3/11 regarding Individual #109 and Individual #110 - Documentation from psychiatry/neurology combined clinic beginning November 2010 - All data presented, doctor's orders and Dr. Chavez-Rice's documentation for psychiatry clinic 1/5/11 regarding Individual #37 - Ten examples of the health risk assessment tool for polypharmacy - Minutes and agenda from the first polypharmacy meeting - Active psychoactive medication list by drug class for the months of October, November and December 2010 - These documents: - Identifying data sheet - Consent section (for psychotropic medications) - PST section - PSP and PSP addendums/reviews - Behavioral services section - Health data section - Hospital section - Health status section - X-ray/Lab section (for the last six months) - Psychiatry section (for the last six months) - Side effect screening section - Pharmacy section (for the last six months) - Consult section - Physicians orders (for the last six months) - Integrated progress notes (for the last six months) - Annual nursing assessment - For the following individuals: - Individual #13, Individual #120, Individual #164, Individual #56, Individual #8, Individual #108, Individual #109, Individual #110, Individual #112, Individual #66, Individual #69, Individual #73, Individual #35, Individual #37, Individual #77, Individual #104 Interviews and Meetings Held: - Eugenio Chavez-Rice M.D. facility psychiatrist - Sandy Delong, R.N., Director of Nursing - Salvador Molina, D.O., Medical Director - Amista Salcido, Pharm.D., Pharmacy Director - Valerie Grigg, M.A., BCBA, Director of Behavioral Services - Howard Pray, D.D.S., facility dentist, with Russell Riddell, D.D.S., District Dental Director Observations Conducted:

	o Observation of three psychiatry clinics including the following individuals: • Individual #66, Individual #112, Individual #109, Individual #110, Individual #37 o Observation of PSP meeting o Critical Incident Debriefing o PST Emergency staffing for: • Individual #37 and for Individual #13 o Observation of morning meeting
	Facility Self-Assessment: A review of the facility POI for this monitoring period revealed a self-rating of substantial compliance in provision J1 only. The other facility self-ratings were in accord with the ratings assigned per the monitoring team. A review of the facility POI revealed that while the facility has outlined specific plans/goals to achieve compliance in each area, with the current lack of resources in psychiatry, goal attainment will be difficult.
	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, except for provision item J1. The psychiatry department at the EPSSLC had undergone a complete change of personnel since the previous monitoring review. The facility has recruited a full time psychiatrist who was new to the practice of psychiatry within a supports and services center. The new physician, while excited by the challenge and apparently willing to learn, was in need of mentoring and guidance from a psychiatrist well versed in the provision of services in this environment. It was also noted that the physician, while enthusiastic, was overwhelmed with the current clinical and administrative responsibilities. While psychiatry was interacting with psychology on some levels, there were marked deficits in the interaction. It was apparent that some duties that should fall in the realm of psychiatry were being provided by psychology (e.g., risk/benefit analysis for psychotropic medications). Also, there were areas where psychology could be more integrated with psychiatry (e.g., identification of target symptoms, data collection, collaboration regarding case formulation). The staff from both disciplines were aware of the challenges and the need for increased structure and integration, however, they were also aware of the manpower shortage and history of a lack of clinical resources in psychiatry, which did not lend itself to close collaboration. Currently, the clinic was not organized. Space for psychiatry clinic had been identified, and needed to be prepared for the psychiatrist to begin providing services there. Additionally, the psychiatrist was not integrated into the overall treatment program at the facility. The physician was 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. 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. What was most striking during this review, was that staff overall were caring and invested in the treatment of the individuals and had the desire to see the individuals benefit from treatment.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The facility had not designated a lead psychiatrist, however, as of 11/1/10 had recruited and hired a full time psychiatrist. The two prior consulting physicians were no longer providing services at the facility. The current full time psychiatrist was board certified in adult psychiatry by the American Board of Psychiatry and Neurology and in forensic psychiatry by the American Board of Forensic Examiners. Based on his qualifications, this item is rated as being in substantial compliance. The newly recruited psychiatrist practiced for approximately three months at the El Paso State Center in 1997-1998 and, as such, he was new to the practice of psychiatry in the SSLC environment. The practice of psychiatry in this environment differs significantly from practice in other clinical settings. It may be helpful to provide the newer physicians with some mentoring from other physicians who are more experienced in the SSLC model. The facility should consider the development of a "pearls of wisdom" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility and, thereby, help to ease the transition for both the physician and staff. Although the psychiatrist at the facility was board certified, the report that follows will indicate areas of concern with regard to practice at the facility. It was recognized that many of the challenges to providing care in the facility were out of the physician's control. For example, he had only began work at the facility two months prior to the monitoring review, and the facility had a lack of: • clinical resources • appropriate data for the physician • integration of psychiatry into the overall facility treatment program • appropriate clinical consultation space • administrative support staff It was apparent that there were other difficulties with the physician's practice as well (e.g., documentation issues) that were directly within physician control and are discussed in more detail below. Improvements necessary in the quality of services provided will be reviewed over the course of subsequent monitoring visits.	Substantial Compliance

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J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Per interviews with the new full time psychiatrist, individuals were seen in clinic a minimum of once per quarter for their quarterly medication review. The psychiatrist had started one comprehensive psychiatric assessment per Appendix B. Concerns regarding the adequacy of psychiatric clinical availability remained, even with the recruitment of the new full time physician. For further discussion regarding this, please see section J5 below. At EPPSSLC, 93 of the 134 individuals received psychotropic medications at the time of this onsite review. A review of 16 records revealed varying quality of the documentation in the quarterly medication reviews. There were some basic diagnostic formulations noted, specifically in the psychiatrists "Review of Diagnosis and Treatment Concordance" forms. In general, there were no detailed descriptions of the justification for the use of specific psychopharmacological agents located, nor evaluation and diagnosis in a clinically justifiable manner as required by this provision item. The following are two examples gleaned from this review of 16 records: • Individual # 164 – The most recent quarterly medication review dated 12/9/10 documented psychiatric diagnoses including, "Psychotic Disorder, Generalized Anxiety Disorder, and Obsessive Compulsive Disorder." The most recent diagnostic formulation was dated 6/4/09 and stated, "this resident who was diagnosed with profound mental retardation developed aggressive behavior towards self and others, unmanageable at home with a need to be placed at this facility in March 200 and remains here." This formulation does not include information regarding the diagnoses and what symptoms were present, such that the diagnosis was made. The documentation also did not include information regarding the prescribed medication and what target symptoms were being addressed with the medication. The psychological update evaluation dated 3/28/10 was also reviewed. This document reported diagnoses including Autistic Disorder and Intermittent Explosive Disorder. Per the document request regarding a list of individuals who had a diagnosis change in the year prior to the onsite review, no individuals were identified. Therefore, it was concerning that there was no collaboratively developed diagnostic formulation/treatment plan, as psychiatry and psychology were operating with divergent diagnoses. • Individual # 66 – The most recent quarterly medication review dated 11/9/10 documented psychiatric diagnoses including, "Psychotic Disorder, Dysthymia."	Noncompliance

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		There was no annual psychiatric evaluation included in the record provided, and no case formulation was included in the quarterly medication review documents dated 10/26/10, 10/7/10, 9/2/10, 8/5/10, 7/13/10, and 6/3/10. The documentation also did not include information regarding the prescribed medication and what target symptoms were being addressed with the medication. Per the most recent psychological evaluation update dated 4/12/10, the diagnoses were Anxiety Disorder and Impulse Control Disorder. Per the document request regarding a list of individuals who had a diagnosis change in the year prior to the onsite review, no individuals were identified. Therefore, it was concerning that there was no collaboratively developed diagnostic formulation/treatment plan, as psychiatry and psychology were operating with divergent diagnoses. As illustrated by the examples above, the case formulations reviewed for this monitoring report were either non existent, or brief and incomplete. A case formulation should provide information regarding the individual's diagnoses, including the specific symptom clusters that led the writer to make the diagnosis, factors that influence symptom presentation, and important historical information pertinent to the individual's current level of functioning. For additional information, the staff may want to refer to the following article: Ross, D.E. (2000). A method for developing a biopsychosocial formulation. Journal of Child and Family Studies, 9(1), pp. 1-6. On a positive note, there were some documents reviewed entitled "Psychiatric Diagnosis and Treatment Concordance" which included some improved documentation. It was discussed during the onsite review that, rather than focus on this documentation, the psychiatrist should focus on the comprehensive psychiatric evaluation per Appendix B. This would allow for the development of a total clinical picture and better enable the development of a clinical conceptualization and biopsychosocial formulation. Please see the discussion below regarding J13 for additional information. 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	Per this provision item, individuals prescribed psychotropic medication must have an active positive behavior support plan (PBSP). In all records reviewed, individuals prescribed medication did have a PBSP on file. As indicated in section K of this report, however, overall, the PBSPs did not meet the generally accepted professional standard of	Noncompliance

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	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.	care. Therefore, it must be considered that some psychotropic medications were being used in lieu of, and perhaps as a substitute for, a treatment program. There was, however, no indication that psychotropic medications were being used as punishment or for the convenience of staff. 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. It will be important for collaboration to occur between psychology and psychiatry in case formulation, and in the joint determination of target symptoms and descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. It will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary inclusive of behavioral data and in the process generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and to discuss strategies to reduce the use of emergency medications. It is also imperative that this information is documented in the individual's record in a timely manner. <u>Emergency use of psychotropics</u> During the onsite monitoring review and per the record review, it appeared that the facility had reduced the use of emergency psychotropic medication for individuals during periods of agitation/aggression. Documentation in the month of December 2010 revealed that there had been only one episode of emergency psychotropic medication. This was the lowest number in the previous six months. The one application was in the case of Individual #104. Following administration of the medication (per a telephone order at 3:41 a.m.) the individual was seen by psychiatry (per a progress note at 1:30 p.m. later that same day). This was a reduction from the month of November 2010 where there were eight instances of the use of emergency psychotropic medications (these eight instances were attributable to Individual #104 and Individual #8). • Review of the record of Individual #104 did not reveal progress notes from psychiatry in response to the need for additional medications. There was, however, documentation of PSP addendums in response to the need for additional medication inclusive of specific behavioral interventions targeting the reduction of challenging behaviors.	

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		• Review of the record of Individual #8 revealed gaps in the record. It was apparent that Individual #8 received multiple intramuscular injections of medication 11/10/10 for a total of Phenobarbital 355 mg, Ativan 6 mg, Haldol 5 mg, and Benadryl 50 mg. Per the physician's orders, this resulted in a transfer to the emergency room with a diagnosis of "severe delirium." Unfortunately, hospital records requested for this monitoring report were not provided for review. A facility-generated hospital return noted dated 11/13/10 revealed hospital discharge diagnoses as "severe delirium…self inflicted human bite…status post respiratory failure secondary to medications" among others. Per the documentation, ventilator support was required. A review of available records regarding this individual did not reveal documentation of PSP addendums or other team interventions. This case is extremely concerning as the use of multiple medications in elevated dosages resulted in serious side effects for Individual #8 requiring inpatient hospitalization and ventilator support. Data for the month of October 2010 revealed seven instances of the use of emergency psychotropic medications, the month of September 2010 revealed 10 instances of the use of emergency psychotropic medications, and the month of August 2010 revealed six instances. There was a disparity in reported data, as information received from pharmacy (for the month of November 2010 only) indicated 14 episodes of the use of emergency psychotropic medications attributable to five different individuals. This points to the need for improved data collection. The use of emergency psychotropic medication is one additional set of data that should become part of the facility's QA program (see section E of this report).	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical	Per interviews with dental clinic staff and the regional Dental Director, the facility had recruited and hired a part time contract dentist. The onsite dental clinic was not currently utilizing any pretreatment sedation. Community dentists were treating those individuals who required sedation. Unfortunately, the dental clinic staff were not aware of which individuals were going off campus for treatment or what medications were being utilized for pretreatment sedation. It was discussed, and dental staff agreed that arrangements for this off campus care should be scheduled via the facility dental clinic. This may soon be a moot point, however, as dental staff reported that the facility will soon be utilizing TIVA. The start date for TIVA at the facility was not known and dependant on the completion of a contract for services. Dental staff were using a three visit protocol developed by dentistry in an attempt to desensitize individuals to dental services. While the dental staff had noted some minimal success with this process, they had not formally collaborated with psychology in the development of individualized desensitization plans.	Noncompliance

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	services, and shall be monitored and assessed, including for side effects.	A request for documentation regarding desensitization plans returned a document that stated, "at this time there are no active medical or dental desensitization plans in place." This was in conflict with another document request where copies of specific desensitization plans were requested. This resulted in the production of 10 authored plans, however, it was apparent that these had not been implemented by the facility. In an effort to reduce the reliance on pretreatment sedation discussed below, the implementation of these plans was recommended. Review of the Sedation Trend Report provided in response to a document request for information regarding pretreatment sedation revealed a downward trend in the numbers of individuals receiving sedation prior to a procedure over the past two quarters. For example: • In the months of June 2010, July 2010, and August 2010, 17 individuals received pretreatment sedation for dental clinic and six individuals received pretreatment sedation for medical clinic. This equated to a total of 23 pretreatment sedations. • In the months of September 2010, October 2010, and November 2010 this report noted nine instances of dental pretreatment sedation and no instances of medical pretreatment sedation for a total of nine pretreatment sedations. The report did not designate if the sedation was provided for on campus evaluations versus off campus evaluations. Review of the Pharmacy and Therapeutics Committee meeting minutes revealed that the facility medical director "has plans to end pre-sedation practice here at the facility, as much as possible." A review of the total Medical Sedation Report (inclusive dates not noted) dated 11/8/10, revealed that of a total of 14 individuals (with a cumulative total of 21 sedation episodes), seven individuals or 50% were receiving concomitant mental health care. A review of the total Dental Sedation Report (reporting period from 9/1/09 to10/31/10), revealed that of a total of 32 individuals (with a cumulative total of 99 sedation episodes), 25 individuals (78 %) were also prescribed psychotropic medications. Documentation of the coordination of the pretreatment sedation process with psychiatry was requested. In return, examples of a "pre-sedation assessment" form were returned. Per these documents, the planned procedure was noted, as was the individual's current psychotropic medication regimen, however, the medication planned for use as pretreatment sedation was not included in the documentation. While this is a good first step, because it informs the psychiatrist that the individual will be receiving additional	

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		medications, additional information is necessary to ensure that the individual does not receive medication that would negatively interact with his or her current regimen. Given the data presented above, with the majority of individuals requiring pretreatment sedation having concomitant mental health issues, the inclusion of the treating psychiatrist in the informational loop regarding pretreatment sedation for dental clinic is necessary. It was suggested that this information (e.g. the individual's scheduled for TIVA on a particular date, the individuals scheduled for community dental care, the type of medication and dosage planned for pretreatment sedation) be provided to psychiatry so that the psychiatrist will be aware of the plan and can review the psychotropic medication regimen for any potential contraindications. Other individuals were receiving pretreatment sedation for medical clinic (e.g. Ativan) and this information would be useful to the psychiatric physician as well given the potential for interactions between psychotropic medications and the additional medication prescribed for pretreatment sedation. As 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, and as 70% of the individuals requiring pretreatment sedation (for either medical or dental services) were also treated with psychotropic medications, communication regarding the utilization of pretreatment sedation must be improved.	
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.	As of 12/31/2010, there was one full time psychiatric physician providing services at the facility. This physician was onsite five days per week. He was responsible for all clinical consultation. This psychiatrist was board certified in adult psychiatry per the American Board of Psychiatry and Neurology and in forensic psychiatry per the American Board of Forensic Examiners. In contrast to the prior monitoring review, where psychiatrists were performing monthly medication reviews, the psychiatry clinic was currently providing quarterly medication reviews and follow-up for medication adjustments and psychiatric crisis more frequently or as indicated. With the lack of resources in psychiatry, this would be the most frequent monitoring that the facility would likely be capable of. The generally accepted professional standard of care would be minimally quarterly, however, the facility should ensure that quarterly reviews (rather than more frequent monthly reviews) meet any other regulatory requirements of the facility.	Noncompliance

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		There were a total of 93 individuals assigned to psychiatry clinic for medication management, and the physician estimated his total caseload at 110 individuals. Taking the lesser of the two estimates, this equated to 31 quarterly medication reviews per month. Additionally, the physician would need to perform 93 comprehensive assessments annually, plus attend PST meetings, polypharmacy meetings, neurology clinic, provide emergency psychiatric consultation, and more frequent monitoring for individuals whose medication dosages or regimen had recently been adjusted. Currently, the psychiatrist had no support staff, and thus was functioning alone. In order to utilize the clinical time fully, administrative support for the psychiatrist was recommended. With a current caseload of 93 individuals, this also resulted in 39 scheduled clinical contacts per month (quarterly medication reviews and annual evaluations). Allowing 90 minutes for a quarterly medication review and three hours for a comprehensive annual assessment, 70.5 hours of clinical consultation time per month would be consumed prior to the psychiatrist's participation in any other required activity. This indicated that 16.8 hours of physician time per week (or 0.42 FTE) are required for this activity (allowing for a total of 4.2 weeks per month). Add to this the evaluation of new admissions, attendance at meetings (e.g., polypharmacy committee, behavior therapy committee, physician's meetings, behavior support planning), and any other clinical activity. And then, add to this the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology. Based on this, a minimum of 1.5 FTE psychiatric physicians appear to be necessary at this facility. The monitoring team can be available to further discuss the determination of optimal FTEs if the state would like.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	A review of the facility's current policy and procedure manual did not reveal a policy and procedure regarding the provision of psychiatric care. In response to a document request for all policies, protocols, procedures and guidelines that related to the role of the psychiatrist at the facility, it was reported that there were "no changes/updates on policy since last monitoring visit." It should be noted that during the previous monitoring period, it was reported that there were no local policies. As such, it appeared that the overarching DADS policy regarding Psychiatric Services dated 7/20/10 would outline psychiatric services at the facility. The DADS policy appeared to be in line with the Settlement Agreement and the Health Care Guidelines. The facility should determine whether facility-specific policies would be of benefit to the operation of the psychiatry department. Per a request for examples of psychiatric evaluations performed according to Appendix B, documentation of one partially completed evaluation was provided. As the evaluation	Noncompliance

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		was incomplete, it was impossible to assess the quality. Per a conversation with the facility psychiatrist, he had been performing some diagnostic/treatment concordance assessments, however, he had not been focused on performing comprehensive assessments per Appendix B. 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. During the review, three psychiatric clinics were observed (for additional information regarding this please see the discussion regarding J8). In all three instances, the physician along with the assigned psychologist, nurse case manager, direct care staff, and QMRP met with the individual for psychiatry clinic. Appropriate clinical observation/discussion lasting anywhere from 20 to 40 minutes was held with the team and the individual. It was obvious from the interaction that the individual was a participant in the clinic. In all three clinic observations, the physician appeared to be familiar with the individual's history, and had the medical record open, reviewing documents from the record during clinic. In all three observations, other staff, including the nursing case manager, QMRP, psychology, and direct care staff were in attendance. In all three observations, the psychiatric practitioner led the discussion and interacted with other team members, but primarily the individual. Issues reported in the prior monitoring report specifically related to physical plant and the lack of comfort in psychiatry clinic were resolved, to some degree. At the time of this monitoring review, psychiatry clinic was being conducted in the medical area. There were challenges with this, specifically the need to share the clinical space with the primary care staff and neurology, as well as frequent noisy interruptions from an overhead paging system, causing one individual to state, "Can't you shut that off?" Both the facility Medical Director and psychiatrist reported plans to repurpose a large room in the medical clinic area for an office and clinic space for psychiatry. It was notable that in all clinic observations, staff were seated and comfortable. Additionally, in sharp contrast to the prior monitoring visit, clinical consultations were not rushed, demonstrated rich discussion between the staff participants, and fully engaged the individual. While this allocation of space was positive, it also alleviated the need for the psychiatrist to travel to the individual homes. There was concern that the potential for reduced presence in the individual homes could be detrimental to psychiatry's overall integration into the facility system. In an effort to "keep it real," periodic walking visits to the individual homes was recommended.	

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J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss Screen is an instrument that was developed to identify individuals who may need a psychiatric evaluation. Per an interview with the Director of Behavioral Services (Psychology) and requested record review, the facility had performed one Reiss Screen: for Individual #161. A second individual was admitted to the facility in the interval since the last monitoring review, Individual #144. Unfortunately, this individual was not screened via the Reiss Screen. Per documentation provided regarding the absence of the screening document for Individual #144: "…was admitted…on ……..[staff name] did a psychological update on September 15, 2010. No Reiss Screen was performed. [Staff name] was released from…employment…Reiss Screen was not completed by another psychologist…will be completing the Reiss Screen…on or before January 28, 2011." The Director indicated that screening had not yet been conducted for those individuals residing at the facility who were not participating in psychiatry clinic. There were currently 41 individuals at the facility who were not enrolled in psychiatry clinic and would be appropriate for Reiss Screening.	Noncompliance
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 and validity of the identified individual target behaviors. Further, in all clinic observations, the data provided to the physician regarding target symptom monitoring was at least three weeks old. Per staff interviews, this was due to the facility staff compiling data monthly. This was not adequate. For psychiatry to make appropriate determinations regarding response to medications that are data based, data collection and analysis must be up to date at the clinical encounter. A review of the psychological and psychiatric documentation for 16 individual records	Noncompliance

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		did not reveal case formulations that tied the information regarding a particular individual's case together. Psychology and psychiatry need to formulate diagnoses and plans for treatment as a team. There was no documentation located regarding 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. The facility did not have a system to integrate pharmacological treatment with behavioral and other interventions. Review of the records did not reveal any collaborative or combined case assessments or diagnostic formulations. There were beginnings of integration between psychiatry and psychology, specifically the reported attempts by psychiatry to attend some PSP meetings. There were also opportunities for interaction during psychiatry clinic; these were observed during three clinic observations performed during this monitoring review and were a base upon which to build integration. To reiterate, one area of integration that required attention was regarding the use of data. Both psychiatry and psychology staff voiced concern regarding the accuracy of data collection, and the accuracy of the choice of individual target behaviors. It was also notable that, while there were graphs of data presented to the physician, these did not include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). Please also see section K of this report. Medication decisions made during clinic observations conducted during this onsite monitoring review were based on lengthy (minimum 20 minute) observations/interactions with the individuals as well as the review of information provided during the time of the clinic. In the three clinic observations performed during this onsite review, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them and discussed the plan, if any, for changes to the prescription regimen. This was good to see. There was cause for concern because, during the clinic observations, alterations to the psychopharmacological regimen were made, and in the cases of three individuals, these alterations were comprised changes of more than one medication dosage (either a titration upward or downward) and/or the addition or discontinuation of other medications. This reportedly resulted in increased behavioral challenges for these individuals, and the medications/dosages were soon revised as a result. For additional	

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		information regarding this questionable practice, please see paragraphs J13 and J11 below.	
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 psychiatry and psychology staff, psychiatry did not attend meetings regarding behavioral support planning, and was not involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance. Psychiatry verbalized a willingness to become more involved, but indicated that a lack of clinical contact time made this impossible. To meet the requirements of this provision item, there needs to be indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. The psychiatrist was 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 psychiatrist documented an indication for the medication, he did not regularly document the target symptoms for a particular medication. This lack of treatment coordination was what prompted the psychiatrist to begin the review of individual cases regarding diagnostic and treatment concordance. In clinic observations, it was apparent that the psychiatrist was somewhat frustrated by the lack of coordination between psychology and psychiatry as well as experiencing difficulties determining what the defined target symptoms for monitoring were and how to review the data provided. This is an area that is ripe for improvement. Specifically, as stated in other areas of this section J, psychiatry and psychology must learn to work together and how they can assist each other toward the common goal of appropriate treatment interventions. Given that the current facility psychiatrist is new to the DADS system, consideration for mentoring with an experienced facility psychiatrist would be timely. The positive behavior support plans and psychiatric documentation for 16 individuals prescribed psychotropic medication were reviewed. It was difficult to determine collaboration between the disciplines via a review of this document. The psychology staff had begun to utilize graphs for the reporting of behavioral data trends over time. For psychiatry, these graphs would be most useful if they included specific time markers (e.g., start dates of medication, stop dates of medication, dosage adjustments, specific life stressors that may affect behavior) and if they included data up to the date of the psychiatric review. This was only one of numerous areas where psychiatry and psychology will need to develop methods to share information and collaborate regarding the treatment of the individuals at the facility.	Noncompliance
J10	Commencing within six months of	A review of the records of 16 individuals at the facility who were prescribed various	Noncompliance

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	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.	psychotropic medications did not reveal documentation by the psychiatric physician of an individualized specific risk/benefit analysis with regard to treatment with medication as required by this provision item. There were comments regarding the risk/benefit analysis for treatment with psychotropic medications included in the positive behavioral support plans, however, these did not satisfy the requirements of this provision item. As expected, they were incomplete with regard to the inclusion of specific risks, and did not generally include other alternative treatment strategies (other than the PBSP where the documentation was included). Interviews with facility staff revealed that, in an effort to address this documentation requirement, psychology staff were obtaining information regarding psychotropic medication from the pharmacy for inclusion into this document. What was curious was that the risk/benefit/alternatives to medication were being authored and presented to the individuals or their LAR by psychology staff. There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. As discussed with facility staff during the monitoring review, the risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician (also see J14 below), however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same	The facility had in place a review system for polypharmacy that was centered in the pharmacy department. EPSSLC had recently recruited a new clinical pharmacist who was ambitious and energetic. A review of the quarterly drug regimen documents located in 16 individual active records revealed timely reviews in 12 records. The reviews were comprehensive and offered appropriate guidance and recommendations to the physicians. In all of these cases, the treating psychiatrist signed the review. There were four active records where recent documentation was not present. Whether this was due to a delinquency in performing the review or a copy/filing error was not certain. The pharmacy could	Noncompliance

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	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.	consider a tracking mechanism to ensure that all reviews are performed in a timely manner. The facility had recently instituted a polypharmacy committee. Meeting minutes from the first committee meeting were reviewed. Good progress was noted. For example, the November 2010 meeting, minutes stated: "a total of seven individuals' antipsychotic therapies were reviewed…there was a lack of justification for the use of antipsychotic polypharmacy and limited attempts to discontinue antipsychotics. Plans should be clearer with goals of removing one antipsychotic rather than adding on…new psychiatrist has begun to follow individuals, including two on this list, which have been tapered off antipsychotic polypharmacy…it has been consistently found that the indication for antipsychotic therapy is not always appropriate..." A review of the pharmacy quarterly drug regimen review and the psychiatric progress notes did not reveal specific justifications for pharmaceutical regimens. Per interviews with the facility pharmacist and the current facility psychiatrist, there was a focus on the overall reduction of psychotropic medication burden prescribed to each individual. Per review of documents and observation during the review, this medication reduction had not always had positive results for the individual. Please see the discussion regarding J13 below. 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: • Six individuals were prescribed two antipsychotics (reduced from 10 during the previous monitoring review) • Two were prescribed three antipsychotics (an equal amount from the previous monitoring review) The record of Individual #104, who was prescribed three antipsychotics was reviewed. The most recent quarterly drug regimen review performed by the pharmacy was dated 3/9/10. The justification for polypharmacy was unchanged from the prior monitoring period, stating, "resident is stable on present medication." This statement did not suffice for polypharmacy justification. Regarding other classes of medication: • A total of 47 individuals prescribed antidepressant medications.: o Of these, six were prescribed two antidepressant medications (an increase from two in the last monitoring period).	

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		• There were 60 individuals prescribed anxiolytic medications (an increase from 40 in the previous monitoring period).
		  o Of these, two were prescribed two anxiolytic medications (a reduction from five in the previous monitoring period).
		• Ten individuals were prescribed stimulant medication (an increase from six)
		  o There was no polypharmacy noted in this class.
		• Twelve individuals were prescribed sedative medication (a reduction from 21)
		  o There were no individuals prescribed two sedative medications (a reduction from two).
		
		Of the total of 87 individuals prescribed psychotropic medication from any class in the month of October 2010:
		• A total of 22 individuals were prescribed two or more psychotropic medications from the same class.
		• A total of 47 individuals were prescribed three or more psychotropic medications regardless of class.
		  o This was a reduction of 30% from the previous monitoring period. At that time, 68 individuals were prescribed three or more psychotropic medications regardless of class.
		
		As was discussed during the onsite review, in some cases, individuals will require polypharmacy and treatment with multiple medications may be absolutely appropriate and indicated. The prescriber must, however, justify the clinical hypothesis guiding said treatment. The focus on rapid regimen alteration and polypharmacy reduction was concerning, as there was some evidence of negative outcomes for specific individuals. It may be helpful for the facility to review the prescribing trends, as demonstrated above, to determine if there are shifts from prescription from one medication class to another.
		
		In addition, the facility might consider the creation of an additional metric to indicate the number of individuals for whom active medication titrations are in progress, but not yet completed. This would be a listing in addition to the lists of individuals who meet the criteria for polypharmacy as per this provision item and any other relevant facility or state policies.	

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,	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 when indicated, however, data gleaned from the MOSES and DISCUS exams were not consistently utilized in the quarterly medication reviews done by psychiatry. In other words, review of documentation did not reveal documentation of the review or use of this information in	Noncompliance

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	and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	psychopharmacological decision-making. The facility did not have a tracking system for documentation of completion of these assessment tools. Interviews with nursing administration at the facility revealed difficulties in determining who was scheduled for a particular examination at a particular time. It was suggested that the facility could consider a semi-annual schedule for MOSES examinations (e.g., January and June) and a quarterly schedule for DISCUS examinations so that case managers would know to perform an examination for everyone on their caseload who required examination during that period. A review of the quarterly medication review documents for these 16 individuals revealed that in 90% of the cases, timely DISCUS and MOSES results were located in the record, and had been signed by the psychiatric physician. Review of psychiatric documentation, however, did not generally include information regarding the presence or absence of abnormal movements or clinical correlation of the data available from the review of these rating instruments. This was, however, included in the pharmacy quarterly drug regimen reviews. In an effort to address the need for documentation of data review and the impact of said data in clinical decision making, the facility could consider physician education regarding documentation requirements, quality assurance monitoring with ongoing corrective action, or a peer review process utilizing physician reviewers from another DADS facility.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how	A review of the records of 16 individuals did not reveal any specific treatment plans for psychotropic medication. At the time of the onsite monitoring review, the facility psychiatrist reported that he was participating in the PSP process as he was able. A review of requested data regarding the psychiatrist's participation in PSP meetings revealed documentation of attendance in four instances. Other documentation regarding the revised PSP process revealed psychiatry signatures in an additional three of seven instances. Given this disparity, it was apparent that the facility did not have accurate data regarding the psychiatrist's participation. The lack of psychiatry participation in the PSP process was concerning. For example, Individual #109 was prescribed medications including Aripiprazole, Clonazepam, Oxcarbazepine, Ambien, and Clonidine. Other than a listing of the medications and the indications, there was no other documentation included in the PSP regarding pharmacological interventions. Similar documentation deficits were found in the PSP documentation of Individual #132, Individual #100, and Individual #79. Documentation regarding Individual #89, was only slightly better; it reviewed the individual's	Noncompliance

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	this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	medication regimen, and documented the need to reassess the diagnoses and to track specific symptoms at the request of the psychiatrist. The current facility psychiatrist was aware of the difficulties with psychiatric diagnoses and treatment concordance. He had begun to review individuals assigned to the psychiatry caseload with respect to their diagnoses, treatment, and the justification for treatment with a specific medication. These evaluations were brief, and specifically addressed justification of diagnoses and treatment. They did not include specific target symptoms for monitoring. While the physician's initiative was laudable, the requirement of a comprehensive psychiatric evaluation per Appendix B would be a modality to answer the diagnostic justification and treatment concordance question. This was discussed with the physician so that he could channel his efforts into Appendix B evaluations. During the review, it was discussed with members of both the psychiatry and psychology staff that improved integration of their departments will be necessary in order to fulfill the requirements of the agreement. Currently, both departments were unsure of how they could assist each other and what information/services they can obtain from the each other. As additional resources are allotted to the psychiatric department at the facility, it is hoped that there will be 90-day reviews of psychotropic medication that include medication treatment plans that outline a justification for a diagnosis as well as a thoughtful planned approach to psychopharmacological interventions and the monitoring of specific target symptoms to determine the efficacy of the prescribed medication. 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. There were ongoing difficulties with regard to coordination of care between psychiatry and psychology, as well as the psychiatrist making multiple medication alterations simultaneously. Three examples were noted by the monitoring team: • A clinical encounter was observed regarding Individual #109. This individual has a history of diagnoses, including Impulse Control Disorder, Psychotic Disorder, Generalized Anxiety Disorder, and Mental Retardation. Target behaviors for monitoring had been aggression, uncooperativeness, biting, and restraints. Monitoring for psychotic symptoms was not included. Per the psychiatric documentation, although this individual had a reported recent increase in uncooperative behavior, the psychiatrist made the decision to alter	

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		the medication regimen by discontinuing Abilify, Ambien, and Clonidine. Additionally, Seroquel XR was changed to Seroquel. With multiple medication changes made at this clinical encounter, it will be difficult for the physicians to determine what medication change (if any) resulted in either positive or negative effects for the individual. • In an emergency PST meeting regarding Individual #37, increased mood symptoms as well as suicidal ideations were reported. It was noted that this individual had several medication changes (reductions and discontinuations) in the week prior to the exacerbation of symptoms, however, none of the staff present in the meeting (including nursing staff) were aware of what the changes consisted of. In response to the increased behavioral challenges and psychiatric symptoms noted in the emergency PST meeting, a psychiatric clinic was scheduled for the following day and, during which, the medication dosages of Lithium and Clozaril were reportedly returned to their previous levels (prior to the onset of the tapers). Review of the requested medical records did not reveal physicians order sheets or psychiatric documentation for this period of time. Rapid changes in psychotropic medication levels and dosages can result in discontinuation syndromes (e.g., agitation, irritability, and exacerbations of existing mental health symptoms). • A similar situation occurred during the review with respect to Individual #112, where Lithium had been discontinued in late December 2010 along with a taper of Zyprexa. Due to the individual experiencing increased mood symptoms, the medication Lithium was restarted during a clinic observation 1/5/11. The rapid alteration of medication dosages and regimen can result in exacerbations of challenging behaviors and mental health symptoms, as was seen in the case of this individual. In response to observations of these similar situations, the need for a planned thoughtful approach to psychopharmacological adjustments was discussed with the psychiatrist. The physician verbalized his agreement with this generally accepted method of practice, and agreed with that with appropriate behavioral interventions, the need for psychotropic medication can be reduced. Even so, subsequent clinical observation revealed ongoing difficulties. The above approach makes it impossible to determine the effect of medication alterations. Dosage adjustments should be done thoughtfully, one medication at a time, based on the individual's response as determined via a clinical encounter with the individual, and with a review of appropriate target data (both pre and post the medication adjustment). In this way, the physician can determine the benefit or lack	

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		thereof of a medication adjustment and the team can be more confident of the effects of its collaborative treatment planning.	
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 during the previous monitoring review. These remained in effect at the time of this monitoring review. Per an interview with the facility psychiatrist, "this [indicating informed consent] is reviewed as part of the PSP process." Additionally, a review of the facility plan of improvement revealed the following comments regarding consent issues, "a process is in place for obtaining informed consent by the nurse case manager. A consent form is filled out and presented to the Human Rights committee by the QMRP for review before a non-emergency medication is given." Review of the informed consent documents in the medical records available for review revealed that these forms were essentially checklists to ensure that specific information was addressed via the informed consent process. Of the 16 records available for review, 15 had the checklists included in the documentation. Four of these 15 had minimal additional information. For example, in the record of Individual #108, the side effects of Lorazepam and Diphenhydramine were handwritten as follows, "drowsiness, unsteady gait, slow pulse rate, dryness of nose, mouth and throat, nausea." This was incomplete with respect to side effects of these two medications. In general, the documents regarding informed consent located in the medical records were generic and did not include the required components of informed consent (i.e. risks, benefits, side effects, alternatives to treatment). Not only were facility practices not in line with these administrative requirements, the informed consent process at the facility was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the individual's record. Given the importance of informed consent, the development of an facility policy and procedure regarding this topic could be considered.	Noncompliance

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		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. In an effort to address the deficit in informed consent practices, it was recommended that the facility consult with the state office, who, in turn, may want to consider a statewide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Per interviews with the facility psychiatrist, medical director and neurologist, there had been efforts to improve coordination of care between these three disciplines. Specifically, the neurologist agreed to increase his contracted services at the facility to two half days per month. In the past, the clinic was one half day per month (however, during the week of the onsite review it was no longer apparent that the additional half day was going to occur). All three physicians verbalized plans to attend one of the monthly clinics as a group in order for the physicians to review individual cases where medications were being utilized to treat both seizure disorders and mental illness. It was reported that the first consultative clinic was scheduled for 1/19/11. As the physicians begin organizing and participating in this clinical consultation, it will need to be determined if the current contract hours are sufficient (given a four hour clinic per month, 12 times per year, there would be a total of 48 hours of consultation time to allocate between 55 individuals currently prescribed both seizure and psychotropic medications). Collaboration between neurology and psychiatry is imperative. The facility had a total of 75 individuals with seizure disorder diagnoses, 55 of which were also being treated with additional medications prescribed for psychiatric indications, as such, 53.3% of individuals treated in psychiatry clinic were also prescribed seizure medications due to a diagnosis of seizure. Unfortunately, the psychiatric physician was not integrated into the PSP process at the facility. Given the lack of neurology resources, it would likely be necessary for the psychiatrist to provide information to the PST that resulted from clinical consultation. Currently, the facility had one full time psychiatrist, which was not sufficient to allow for participation in the PST process regularly. A review of documentation requested	Noncompliance

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		regarding the psychiatry participation in the PSP process revealed three examples of the psychiatry participation in the PSP in the month of December 2010. Additional PSP examples provided by the facility (specifically PSP performed in accordance with the newly adopted process and format) revealed a total of seven examples. Of those seven, four were prescribed psychotropic medication. The facility psychiatrist had signed the PSP documents (indicating presence and participation) in two of those meetings.	

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. Continue to reduce reliance on emergency psychotropic medications.

3. Improve data collection regarding the use of emergency psychotropic medications.

4. Individualize and implement the desensitization plans for dental and medical clinic.

5. Ensure that psychiatry is aware when an individual requires pretreatment sedation, that he or she is aware of the medication utilized and documents this knowledge in his or her progress notes.

6. 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.

7. Designate administrative support staff for psychiatry.

8. Complete the allocation of appropriate clinical space for psychiatry.

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

10. 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.

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

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

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

14. Provide up to date data regarding specific target symptoms identified for monitoring at psychiatry clinic. This data must be graphed with the inclusion of time lines for medication changes, health issues, or significant life events.

15. Formalization of the interdisciplinary process to review risk/benefit ratios for the prescription of psychotropic medications to include psychiatry, pharmacy, and psychology. This process will also need to identify the alternatives to treatment with medication and interventions that have either been tried or are proposed in an effort to reduce the individual's medication burden.

16. 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.

17. Consider the creation of an additional metric to indicate the number of individuals for whom active medication titrations are in progress, but not yet completed. This would be a listing in addition to the lists of individuals who meet the criteria for polypharmacy as per this provision item and any other relevant facility or state policies.

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

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

20. 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.

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

22. Improve coordination between psychiatry and psychology, specifically with regard to case conceptualization, identification and justification of diagnoses, the identification and definition of specific target symptoms for monitoring, and the monitoring of the response to treatment with psychotropic medications.

23. Individualize the process for Informed Consent.

24. Consult with DADS administration regarding a statewide policy and procedure for Informed Consent.

25. Integrate psychiatry into the PSP process.

26. Begin the planned clinical consultation clinic for psychiatry and neurology.

The following are offered as additional suggestions to the facility:

27. Consider tracking the psychiatrist's participation in the PSP process.

28. Consider planning periodic non-clinical visits by the psychiatrist to the individual homes in an effort to be visible as a viable member of the facility treatment team and facility community.

29. Consider a procedure where an individual receiving mental health services (i.e. psychotropic medications) cannot receive pretreatment sedation unless it is approved by the treating psychiatrist. This will ensure that the psychiatrist is aware of additional medications provided to the individual.

30. Consider appointing a mentor for the facility psychiatrist, specifically a psychiatrist at another facility who is familiar with the requirements and challenges of working in the DADS system.

31. Consider a tracking system for completion of MOSES and DISCUS evaluations including assignment of specific months to complete the evaluations facility wide.

32. Develop a recruitment/retention plan for psychiatry. The facility should consider the development of a "pearls of practice" book. This would be an information book for psychiatry that outlines information that is specific to the practice of psychiatry within the facility, and ease the transition for both the physician and staff.

33. 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.

34. Consider making the identification of the individual's legal status and the identify/contact information of their legally authorized representative (if any) part of the regular demographic information included in the psychiatric assessment and progress notes. This will make the informed consent process and the regular contact of families/legal representatives during treatment a simpler process.

35. Consider a tracking system for timely completion of quarterly drug regimen reviews by the pharmacy.

36. Consider a review of prescribing trends for particular medication classes.

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 Positive Behavior Support Plans (PBSPs) for: • Individual #104, Individual #34, Individual #99, Individual #7, Individual #73, Individual #126, Individual #109, Individual #18, Individual #81, Individual #188, Individual #56, Individual #111, Individual #43, Individual #77, Individual #78, Individual #10, Individual #42, Individual #120, Individual #92, Individual #61, Individual #14, Individual #115, Individual #39, Individual #38, Individual #96, Individual #13 o Functional Assessments for: • Individual #81, Individual #78, Individual #79, Individual #42, Individual #120, Individual #92 o Monthly PBSP progress notes for: • Individual #109, Individual #18, Individual #78, Individual #81, Individual #39, Individual #104, Individual #115, Individual #59, Individual #188, Individual #111, Individual #34, Individual #7, Individual #99, Individual #126, Individual #77 o Six months of PBSP data for: • Individual #14, Individual #61, Individual #18, Individual #43, Individual #10, Individual #99, Individual #109 o Full Psychological Assessments for: • Individual #65, Individual #95, Individual #169, Individual #63, Individual #183 o Annual Psychological Assessment Updates for: • Individual #23, Individual #24, Individual #59, Individual #112, Individual #10, Individual #61, Individual #14, Individual #13, Individual #155, Individual #104, Individual #99, Individual #18, Individual #109, Individual #144, Individual #161 o EPSSLC Plan of Improvement, dated 12/16/10 o Peer review minutes o Spreadsheet of all Individuals with a PBSP o Individual data graphs for Individual #13 <u>Interviews and Meetings Held</u>: o Valerie Grigg, Director of Behavioral Services o Carmon Molina, Associate Psychologist o Marisella Franco, Associate Psychologist o Mary Webb-Tafoya, Associate Psychologist o Adrian Marquez, Psychology Technician <u>Observations Conducted</u>:

	o Personal Support Team Addendum meeting • Staff Present: - Alex Euzarraga, QMRP; Phillip Bueno, RN case manager; Marisela Franco, Associate Psychologist; Eugenio Chavez-Rice, Psychiatrist • Individual Present: - Individual #13 o Psychology staff meeting • Staff Present: - Valerie Grigg, Director of Behavioral Services; Carmen Molina, Associate Psychologist; Marisela Franco, Associate Psychologist; Mary Webb-Tafoya, Associate Psychologist; Ruben Morales, Psychology Assistant; Rosina Duran, Psychology Assistant; Jaime Altamirano, Psychology Technician; Nohemi Ostos, Psychology Technician; Adrian Marquez, Psychology Technician o Peer review meeting • Staff Present: - Valerie Grigg, Director of Behavioral Services; Carmen Molina, Associate Psychologist, Marisela Franco, Associate Psychologist; Mary Webb-Tafoya, Associate Psychologist • Individual Discussed: - Individual #73 o HRC/BTC meeting • Staff Present: - Gloria Loya, Human Rights Officer; Alex Euzarraga, QMRP; Phillip Bueno, RN case manager, Marisela Franco, Associate Psychologist; Isabel Ponce, Ombudsman • Individuals Discussed: - Individual #66, Individual #45, Individual #157, Individual #9, Individual #39, Individual #100, Individual #144, Individual #3, Individual #83, Individual #113, Individual #116, Individual #104 o Psychiatry meeting • Staff Present: - Eugenio Chavez-Rice, Psychiatrist; Santa Moore, QMRP; Ofie Amor, RN; Giovanna Villagran, Clinical Pharmacist; Mario Rodriguez, Associate Psychologist; Armida Moya, RN Case Manager; Carmen Molina, Associate Psychologist; Dora Felix, Vocational Services • Individual Presented: - Individual #37 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), and • Implementation of behavior support plans
	Facility Self-Assessment: EPSSLC's Plan of Improvement (POI) indicated noncompliance for each item of this provision except K2, K9, and K11. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's POI report except for items K9 and K11. K9 is rated as being in noncompliance because, although PBSPs existed, the quality of many of those plans was not adequate to warrant a substantial compliance rating. K11 was rated as being in noncompliance because no objective evaluation (i.e., treatment integrity) existed to determine if the plans were understood and correctly implemented by direct care professionals, and direct observation suggested PBSPs were not consistently implemented with integrity. More detailed reasons for the discrepant evaluations are discussed below. The POI established long-term goals for compliance with each item of 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 likely take some time for EPSSLC to make these changes, it may be useful for the facility 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.
	Summary of Monitor's Assessment: Although only one of the items in this provision was found to be in substantial compliance with the Settlement Agreement, there was progress in several items. These include: • The development of the skills and management competencies of Director of Psychology (K2) • The establishment of internal peer review (K3) • Several improvements to the data collection system (K4) • The beginning of functional assessments (K5) • The continued development of goal directed psychological therapies with measurable objectives and treatment expectations (K8) • The modifications of some Positive Behavior Support Plans (PBSPs) reflecting data-based decisions (K4) • The beginning of individualized graphing of target behaviors at intervals adequate for interpretation (K4 and K10) There were also areas that the monitoring team believes require immediate attention. Those areas include: • Ensuring all psychologists are enrolled in coursework toward becoming a board certified behavior analyst (K1) • Ensuring that all target behavior and replacement behaviors are collected with integrity (K4 and K10) • Ensuring that PBSPs include specific and precise interventions, based on the results of functional assessments, for decreasing undesired behavior (K9)

	• Systematic training of all direct care professionals (DCPs) in the implementations of each individuals PBSP (K12) • Ensuring that PBSPs are implemented with integrity (K11)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals 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 being in noncompliance because the psychologists at EPSSLC were not yet demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification, and the lack of consistent quality of the positive behavior support plans (see K9). At the time of the onsite review, the Director of Behavioral Services was the only member of the Psychology Department to be a board certified behavior analyst (BCBA). Two of the department's five psychologists, however, were enrolled in course work toward becoming BCBAs. Two other psychologists were committed to begin coursework in the fall of 2011. The Director of Psychology provided supervision of psychologists enrolled in the BCBA program. The department had developed a plan to ensure that the remaining psychologist attained BCBA certification.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility attained substantial compliance with this item. At the time of the onsite review, the Director of Psychology had a master's degree, was a certified applied behavior analyst, and had five years of experience working with individuals with intellectual disabilities. Supervisees interviewed indicated they had positive professional interactions with, and received professional support and leadership, from the director of psychology. Finally under the director's leadership, several initiatives have begun leading toward the attainment of compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	EPSSLC had recently begun internal peer review meetings. At the time of the onsite review, however, internal peer review had not consistently occurred, and the facility did not have external peer review in place. Therefore, although the establishment of internal peer review represented an important improvement from the last facility review, this item is rated as being in noncompliance.	Noncompliance

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		The internal peer review meetings at EPSSLC provided an opportunity for psychologists to present cases that were not progressing as expected. During the peer review meeting observed by the monitoring team, there was active discussion and several examples of staff sharing strategies and suggestions to better identify the variables affecting Individual #73's undesired behaviors. Review of minutes from these meetings indicated that peer review meetings were attended by the majority of psychologists in the department, however, the minutes also indicated that the meetings did not consistently occur weekly. It is recommended that peer review meetings be scheduled and occur weekly. 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 professionals familiar with applied behavior analysis (ABA) and outside EPSSLC (e.g., other Texas DADS psychologists and supervisors). The monitoring team remains available to DADS to further discuss ways to set up an external peer review system. 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.	The monitoring team was encouraged by the many improvements in this provision item since the last onsite review. More work, however, is necessary before the facility achieves substantial compliance on this item. As recommended by the monitoring team in the last report, the facility had extended hourly data collection to all cottages and day programming sites. Additionally, direct care professionals (DCPs) were required to record a zero or a line (or an explanation of why there were no data) in each recording interval if target behaviors did not occur. This method ensured that the absence of target behaviors in any given interval did not occur because staff forgot to record data. The requirement of a recording (i.e., either indicating the frequency of the target behavior, or a zero/line indicating that the target behavior did not occur) in each interval of the data card/sheet allowed the psychologists to review data cards and determine if DCPs were recording data at the intervals specified. The monitoring team reviewed Individual's data sheets in each cottage at EPSSLC, and found that seven of eight (88%) were <u>not</u> completed up to the previous hour. • For two Individuals (Individual #34 and Individual #18), the data sheets were not in the individual notebooks and the DCPs indicated that they did not know their location.	Noncompliance

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		• For Individual #51, the data sheet was filled out up to 10 pm, however the monitoring team reviewed the data card at 7 pm. These observations indicated that DCPs were not consistently recording data. This was a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. It is recommended that the psychology department regularly review data cards, collect data compliance, establish acceptable standards of data compliance, and work with DCPs to attain those levels. Another improvement in the data collection system since the last onsite review was the introduction of data sheets for recording the occurrence of replacement behaviors. Compliance with replacement data was much better than that for the target behaviors. • Six of eight (75%) replacement behavior data sheets reviewed were complete. Since many of the replacement behaviors were complex, it is recommended that DCPs are regularly observed (and retrained if necessary) to ensure that the replacement behaviors are conducted with integrity. As discussed in the last review, 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 (e.g., ABC systems) for some DCPs to collect data reliably. 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 review of EPSSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. The facility has also begun to enhance the flexibility of its data systems since the last onsite review. The director of psychology reported that several psychologists had begun to collect ABC data, however, at the time of the onsite review, no examples of time sampling for high frequency behaviors, or duration measures for behaviors of varying duration (e.g. crying) were implemented. It is recommended that the facility expand its data system to include duration and time sampling measures of target and replacement behaviors. As recommended in the last review, EPSSLC had begun to graph data in increments based on individual needs (rather than all individuals' data graphed in increments of one month, as found during the last review). For example, Individual #13's physical aggression, and several selected antecedent behaviors, were graphed daily to examine the effects of these antecedent variables on his physical aggression. Additionally, during	

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		the Human Rights Committee meeting, the psychologist informed the committee that she planned to graph Individual #3's daily agitation to better assess the effects of a new medication. The monitoring team was encouraged by these improvements in the data system at EPSSLC, and looks forward to seeing more examples during the next onsite review. EPSSLC had improved the process for documenting PBSP modifications. The facility had added the date of the PBSP addendum to each report that had been modified due to the lack of progress (e.g., Individual #73, Individual #43, and Individual #96). In reviewing six months of PBSP data for seven individuals, however, four (57%) indicated no obvious improvement in severe behavior (e.g., aggression or self-injurious behavior) and no indication of a change in the PBSP. For example: • Individual #109's physical aggression showed an increase in frequency for months three, four, and five. • Individual #14's physical aggression indicated an increase throughout the last four months. • Individual #18's SIB and Individual #43's physical aggression remained unchanged throughout the six months of data. It is important that when individuals' data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed, changes are made to the PBSP, and that these changes are documented in the progress notes. Finally a criterion for the revision of the plan was not included in the PBSPs. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data. For example, an individual's functional assessment and his PBSP will be reviewed and modified in three months if his physical aggression does not decrease by at least 20% from its current level.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of psychological assessments for each individual, and the lack of comprehensiveness of some of the functional assessments. <u>Psychological Assessments</u> The director of psychology reported that all individuals at EPSSLC with a PBSP had annual psychological updates. Those individuals without PBSPs did not have annual updates. Additionally, the director reported that not all individuals at the facility had psychological assessments. Five full psychological assessments were submitted for review by the monitoring team.	Noncompliance

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		• All five (100%) included a standardized assessment of intellectual and adaptive ability, and review of personal history. • Three of the five assessments (60%) contained a screening or assessment of psychopathology. • None (0%) of the full psychological assessments reviewed contained an assessment of medical status. • Fourteen of the 15 (93%) annual psychological updates contained intellectual and adaptive scores, personal history, and a summary of behavioral status. • None (0%) of the psychological updates reviewed contained an assessment or update of medical status. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. <u>Functional Assessments</u> No new functional assessments were completed since the last onsite review, therefore, no functional assessments were reviewed to assess compliance with this item. A spreadsheet indicating individuals with PBSPs indicated that 96 individuals at EPSSLC had PBSPs at the time of the onsite review. Only nine (9%) of these individuals , however, had functional assessments. All individuals with a record or assessment reflecting a behavioral disturbance (i.e., behaviors that constitute a risk to the health or safety of the individual or others, and that have been resistant to less formal interventions) should have a functional assessment completed. Because no new documents were reviewed, the comments and recommendations relevant to this item of the Settlement Agreement are identical to those in the last report. Those comments and recommendations will not be repeated here, but are highlighted below: • All functional assessments should include both direct and indirect measures. As discussed in the previous monitoring reports, 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 (e.g., ABC measures) of the functional assessment. 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	

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		assessment remain unclear, or if the PBSP is not producing the desired results, the behavior analyst should then attempt to use other functional assessment tools, such as a functional analysis (i.e., experimental investigation of variables affecting the target behavior) to better understand the variables affecting the target behavior. • 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). • Each functional assessment should contain a clear summary statement identifying the variable or variables maintaining the target behavior. • Hypothesized functions of undesired behavior should be operationally defined. • Functional assessments should be reviewed and modified (and reviews and modifications clearly documented) when an individual does not meet treatment expectations. Despite the lack of completed functional assessments since the last onsite review, the monitoring team did note some progress in this area. For example, in order to better understand the relationship between physical aggression and potential precursors to the behavior, one psychologist conducted a functional assessment to better understand the relationship among physical aggression, eye twitching, and crying for Individual #13. Another psychologist shared with the monitoring team a plan to conduct a functional analysis to identify the conditions associated with lower rates of self-injurious behavior for Individual #73. Finally, several psychologists reported ongoing functional assessments using ABC recording. The monitoring team encourages the facility to continue conducting functional assessments, and look forward to finding them documented in functional assessment reports during the next onsite review.	
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.	EPSSLC's psychological assessments were not based on complete clinical and behavioral data (see K5 andK7) and, therefore, this provision item was rated as being in noncompliance.	Noncompliance

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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.	Some components of the psychological assessments were not completed for every individual at EPSSLC and, therefore, this provision item was rated as being in noncompliance. Additionally, three of the five (60%) full psychological assessments reviewed (see K5), were more than 20 years old. DADS and the monitoring team are determining the conditions for conducting new assessments. Future reviews will evaluate the timeliness of psychological assessments based on those guidelines. Only individuals with PBSPs received annual psychological assessments (see K5). As discussed in K5, the content of the psychological assessment updates/summaries varied. The purpose of the annual update is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should 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. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of two recent admissions (Individual #144, Individual #161) to the facility indicated that this component of this provision item of the Settlement Agreement was in substantial compliance.	Noncompliance
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 services, other than PBSPs, were provided at EPSSLC. The monitoring team noted several improvements in this area relative to the previous review, however, more work is needed to be done before this provision item can be considered to be in substantial compliance. Psychological assessments, PSPs, and PBSPs reviewed did not document the need for these psychological services. The monitoring team did find a PBSP addendum for Individual #178 identifying his need for the Health Education group. It is recommended that need for these services are documented in their annual psychological assessments, PSP, or PBSP. At the time of the onsite review, nine individuals participated in counseling/psychotherapy (eight individuals participated during the last onsite review). The facility continued to offer three therapy groups; Anger Management, Health Education, and Circles (a group focusing on the establishment and maintenance of healthy relationships). A review of documentation revealed that the services included: • A plan of service • Goals and measurable objectives	Noncompliance

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		• Documentation reflecting evidence-based practices • Services included in progress notes • Qualified staff (i.e., psychologists with a degree in counseling) providing the services These psychological services, however, did not include these necessary components: • 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 It is recommended that the facility continue to determine whether each individual needs psychological services other than PBSPs and should develop those needed psychological services.	
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.	This item was rated as being in noncompliance because many of the interventions appeared general and were not clearly based on functional assessment results. Of the 26 PBSPs reviewed, 14 were completed or updated since the previous review, and therefore, were the focus of the review for evaluating improvements since the previous report. Every PBSP reviewed had the necessary consent and approvals. All of the PBSPs contained descriptions of data collection procedures, baseline data, and treatment expectations and timeframes. All PBSPs reviewed contained procedures for training replacement behaviors, but not all presented clear instructions that would likely be implemented by DCPs with integrity (see K5). For example, Individual #78's PBSP offered the following instructions for training of her replacement behavior of using stimulating objects: • An array of objects should be available to manipulate • Offer objects with different textures and sounds to stimulate her senses • Offer magazines for manipulation In order to ensure that DCPs are correctly providing the training of this replacement the objects need to be more completely identified, and the procedures for training need to be more completely described (e.g., how many training trials, when are they conducted, etc.). None of the PBSPs reviewed included specific instructions for how to train replacement behaviors. It is recommended that all replacement behaviors include specific skill acquisition plans for training. Moreover, these plans should be written and	Noncompliance

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		developed following the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. 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). All PBSPs reviewed included descriptions of target and replacement behaviors, however 53% of these were not operational. For example: . Individual #99's definition of Flight was defined as Individual #99 "…carrying out a plan to flee…that is potentially dangerous." This definition required the reader to infer if Individual #99 did indeed have a plan to flee, and if he were allowed to flee, that it would be dangerous. An operational definition should not require DCPs to infer an individual's intentions or the potential danger of the behavior. An operational definition of Flight would only include observable behavior such as far he went without supervision, etc. • Individual #7's PBSP defined aggression as pushing, kicking, biting, throwing objects, or in any way attempting to cause bodily harm to others. This definition also required DCPs to infer Individual #7's intentions. On the other hand the following represent operational definitions that were operational, clear, and complete: • Individual #43's physical aggression was defined as hitting, pushing, kicking, or throwing objects at staff. • Individual #81's SIB was defined slapping face or head, or pinching neck or body. All PBSPs should include operational definitions of target and replacement behaviors. All 14 recent PBSPs described antecedent and consequent interventions, but only three (21%) were rated to be useful for weakening an undesired behavior. Examples of ineffective interventions included: • Individual #9's intervention for self-injurious behavior (SIB) consisted of (1) blocking, (2) offering a variety of activities (e.g., change in environment, a snack, favorite TV show), and (3) encouraging Individual #9 to communicate what was wrong. Although only 9% of the individuals at EPSSLC had a formal functional assessment report (see K5), all the PBSPs reviewed had a section of the working plan that summarized the hypothesized function of the undesired behaviors. Individual #9's hypothesized function of his SIB was negative reinforcement. That is, it was hypothesized that escape or avoidance of activities, interactions,	

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		or physical pain maintained his SIB. The above intervention, however, was not clearly related to this hypothesized function. Although the replacement behavior of teaching communication and encouraging him to communicate was consistent with this hypothesized function, attempting to identify what he wants <u>after</u> he engages in SIB would likely serve to increase the future probability of his SIB, rather decreasing it. • Individual #81's PBSP hypothesized that his aggression was maintained by negative reinforcement, but his intervention following aggression included attempting to find out what he wants and providing it. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. Only one (Individual #7) of the 14 PBSPs reviewed (7%) included a history of prior interventions strategies and outcomes. It is recommended that all PBSPs include a brief history of interventions section Five of 14 PBSPs (29%), included good examples of positive reinforcement to strengthen desired behavior (Individual #73, Individual #126, Individual #18, Individual #81, and Individual #111). For example: • Individual #111's antecedent intervention specified the use of edible reinforcers and one minute of uninterrupted special attention for the absence of the target (undesired) behaviors. • Individual #73's intervention following the target behavior specified that after she calmed down, to offer her reinforcing activities, such working with beads, painting her nails, or applying makeup. Additionally, Individual #73's PBSP included a flow chart of the hierarchy of reinforcers that served as an excellent model of the use of positive reinforcement. Three of the 14 PBSPs reviewed (21%) contained clear, precise interventions, based on functional assessment results that were arranged so as to potentially weaken the undesired behavior (Individual #73, Individual #43, and Individual #188). Interestingly, all three examples represented target behaviors maintained by staff attention and/or tangible items. All three examples included antecedent procedures that encouraged staff to provide attention for the absence of undesired behavior, and ensured that they did not give more attention to negative behaviors than positive behaviors. Once the target behavior occurred, all three PBSPs included specific interventions (such as reducing crowding and verbal/physical redirection for Individual #73), however, the consequent interventions included that each individual should <u>not</u> receive more staff attention	

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		following undesired, relative to desired behaviors. Finally, all three PBSPs specified that these individuals be provided with attention and/or reinforcing activities once the aggression had stopped. It is recommended that the facility build on these three PBSPs and, for the next review, focus on the development of PBSPs based on functional assessment results for target behaviors hypothesized to be maintained by negative, as well as, positive reinforcement.	
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 review. 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, the facility had begun to graph some individual's data 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 consistently 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 year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	This provision item was rated as being in noncompliance because, at the time of the onsite review, the facility did not demonstrate that PBSPs could be understood and reliably implemented by DCPs. As discussed in the last report, EPSSLC used 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. The most direct way, however, to ensure that PBSPs are implemented as written is to implement a system to systematically monitor treatment integrity. At the last review, EPSSLC did implement a system to monitor and ensure treatment integrity. During this review, however, the director of psychology indicated that this tool was not effective and the facility was no longer using it. It is recommended that an effective treatment integrity system be consistently used throughout the facility, data regularly tracked and	Noncompliance

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		maintained, and minimal acceptable integrity scores established. In the absence of treatment integrity data, the monitoring team attempted to assess if PBSPs were understood and correctly implemented by asking DCPs how they would respond to various target behaviors and compare their responses to those instructions written in the PBSPs. Additionally, when the monitoring team observed the occurrence of a target behavior, it compared the DCP's response with that specified in the PBSP. • All staff interviewed indicated that they understood each individual's PBSP. • The monitoring team observed Individual #104 attempts to engage in pica. The DCP called psychology staff, and those staff appeared to follow the intervention specified in the PBSP. • The monitoring team also observed Individual #188 engage in disruptive behavior. Her PBSP specified that staff provide minimal attention to the behavior, and direct her to her room until the disruptive behavior stops. Following the occurrence of disruptive behavior, the DCP called psychology staff for assistance and Individual #188's disruptive behavior eventually subsided. The room timeout, however, was never implemented. These observations suggest that DCPs were not consistently implementing Individuals' PBSPs. The monitoring team noted that often (as in these two examples), when potentially serious target behavior behaviors occurred in the cottages, the psychology staff was called. In the above examples, the DCPs appeared to wait to implement specified interventions until the psychology staff arrived. Moreover, the staff working with Individual #188 left the area (to work with other individuals in the cottage) when the psychology staff arrived. Additionally, although the DCPs interviewed appreciated the consistent help from psychology staff, their perception appeared to be that the psychology staff were responsible for addressing individuals' behavior problems. The monitoring team believe that DCPs will not consistently collect required data (see K4), or adequately implement PBSPs, until they understand that managing individual behavior is their job. It is suggested that the psychology staff role in addressing behavior problems be modified from the primary <u>implementer</u> of PBSP interventions, to the <u>trainer</u> of behavior support plans.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all	As reported in the previous review, each psychologist at EPSSLC maintained logs documenting DCP training on each individual's PBSP. The trainings were conducted by psychologists, psychology assistants, and psychology technicians prior to PBSP implementation and whenever plans changed. These trainings, however, were not	Noncompliance

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	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.	standardized and did not consistently include a competency-based component. 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 all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. In order to meet the requirements of this provision item, it is recommended that staff training procedures include a competency-based component, and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.	
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.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, EPSSLC had a census of 134 individuals and employed five psychologists responsible for writing PBSPs. Additionally, the facility employed two psychology assistants and four psychology technicians. None of these psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least five psychologists with BCBAs.	Noncompliance

Recommendations:

1. The facility should ensure that all psychologists responsible for writing PBSPs attain BCBA certification.

2. Peer review meetings should be scheduled and occur weekly.

3. The facility should establish external peer review.

4. Operating procedures for both internal and external peer review committees need to be established.

5. It is recommended that the psychology department regularly review data cards, collect data compliance, establish acceptable standards of data compliance, and work with DCPs to attain those levels.

6. The facility should ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each cottage and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals.

7. It is recommended that the facility expand its data system to include duration and time sampling measures of target and replacement

behaviors.

8. When individuals' data trends in an undesirable direction (or continues with no improvement), hypotheses should be developed, changes made to the PBSP, and these changes should be documented in progress notes.

9. A specific and individualized criterion for review of each PBSP should be established, and the decision to revise should be based upon the data.

10. Each individual's record should contain a psychological assessment that consists of an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status.

11. All individuals whose records indicate a behavioral disturbance should have a functional assessment of the variable or variables affecting the individual's target behaviors.

12. All functional assessments should include both direct and indirect measures.

13. All replacement behaviors should include specific skill acquisition plans for training. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility.

14. Each functional assessment should contain a clear summary statement identifying the variable or variables maintaining the target behavior.

15. Hypothesized functions of undesired behavior should be operationally defined.

16. Functional assessments should be reviewed and modified (and reviews and modifications clearly documented) when an individual does not meet treatment expectations.

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

18. Each individual's psychological assessment 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

19. All Individuals should have annual psychological assessment updates.

20. The annual psychological assessment update should 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.

21. The need for psychological services (other than PBSPs) should be documented in each Individuals annual psychological assessment, PSP, or PBSP.

22. 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

23. All PBSPs should contain operational definitions of target and replacement behaviors.

24. All PBSPs should include a brief history of interventions section.

25. All strategies for weakening undesired behaviors should be consistent with each individual's functional assessment results.

26. Interventions for responding to target behaviors should specify precise, clear, and individualized procedures.

27. Individual's graphs should consistently contain clear demarcation of changes in medication, health status, or other relevant events.

28. It is recommended that a treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established.

29. Staff training procedures should include a competency-based component and the development of a centralized system to ensure that all staff are trained in the implementation of each individual's PBSP.

The following are offered as additional suggestions to the facility:

30. In addition to the long-term POI goals, it may be useful for the psychology department to establish short-term goals (e.g., for the next six months) so that the psychology staff can better mark their progress toward substantial compliance.

31. It is suggested that external peer review be extended to other Texas DADS, BCBAs and supervisors (perhaps by teleconference).

32. It is suggested that the psychology staff's role in addressing behavior problems be modified from the primary implementer of PBSP interventions, to the trainer of behavior support plans.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 7/20/10 o DADS Policy#006: At Risk Individuals, 10/5/09 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044: Medical Emergency Response, 7/21/10 o EPSSLC: Communication with Hospitals and Other Acute Care Facilities, 91/2009 o EPSSLC: End of Life Advanced Care Planning, 8/31/2009 o EPSSLC: Medication Administration: General Guidelines 1/2009 o EPSSLC: Operating Instructions Seizure Management, 7/2008 o EPSSLC: Policy #5.2.34: Automated External Defibrillator, 6/15/07 o Collaborative Practice Agreement Practice Protocol for a Nurse Practitioner or Other Advance Practice Registered Nurse in Texas o Mortality Reviews for individuals who died between July 2010 and December 2010 o Listing, Individuals with seizure disorder o Listing, Individuals diagnosed with pneumonia o Listing, Individuals with diabetes mellitus o Listing, Individuals diagnosed with cancer o Listing, Individuals diagnosed with pica o Listing, Individuals hospitalized and sent to emergency department o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, health management plans, diabetic records, seizure records, vital sign sheets, bowel records, MARs, annual nutritional assessments, dental records, annual PSPs, and PSP addendums for the following individuals: • Individual #74, Individual #8, Individual #52, Individual #113, Individual #106, Individual #100, Individual #16, Individual #11, Individual #6, Individual #23, Individual #178, Individual #10, Individual #102, Individual #34, Individual #17, Individual #15, Individual #115, Individual #41, Individual #73, Individual #29 o Seizure clinic notes for the following individuals: • Individual #11, Individual #8, Individual #1, Individual #66, Individual #155, Individual #59, Individual #45, Individual #25, Individual #15 Interviews and Meetings Held:

	o Salvador Molina, DO, Medical Director o Eugenio Chavez-Rice, MD, Psychiatrist o Richard Brower, MD, Neurologist o Sandra DeLong, RN, Chief Nurse Executive o Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator Observations Conducted: o Neurology clinic o Medical clinic o PSP Meeting o Cottages and dorms o Day services areas
	Facility Self-Assessment: The facility rated itself noncompliant in all areas of this provision of the Settlement Agreement. Observations, interviews, attendance at facility meetings, review of policies, procedures, and multiple documents, including the active records of individuals, showed improvement in some provision items of section L of the Settlement Agreement, and no improvement in others. In those areas of improvement, programs had been partially implemented or just recently implemented. These findings resulted in the monitoring team's ratings being congruent with the facility's self-assessment ratings of noncompliance with all provision items.
	Summary of Monitor's Assessment: Progress from the previous monitoring visit was seen in several areas. The previous medical director retired at the end of October 2010. The new medical director assumed the responsibilities on 9/1/10. A full time psychiatrist was hired and a joint neurology-psychiatry clinic was scheduled to begin. The advanced practice nurse continued to assist the medical director with completing annual medical summaries, but she had reduced her hours to 8-16 hours per week resulting in less primary care coverage. Under the leadership of the medical director, several positive changes were underway in the department. Documentation of medical care and hospital follow-up had improved. Clinical guidelines had been developed to aid in the provision of medical care. A hospital return policy had also been drafted. The use of pretreatment sedation at the facility was under review and the numbers of individuals receiving sedation for medical and dental procedures was decreasing. There had not been an external review of medical services at the time of this onsite review. There were serious issues with the mortality review process. First, there was a significant delay of five months prior to completion of the clinical death reviews and no administrative death reviews had occurred. Moreover, the clinical death reviews that were completed did not appear to take into consideration valid recommendations that were provided by internal reviewers. There was no mechanism in place to

	demonstrate what actions had occurred as a result of mortality reviews. The facility had not implemented a medical quality review system but development was expected to begin after the clinical guidelines, which outlined the expectations of care, were implemented.

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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.	**Overview** The medical staff was overseen by a full time medical director. He was recently appointed after the retirement of the previous medical director who had worked at the facility for many years. The new medical director was committed to the provision of appropriate medical, participation in the team multidisciplinary process, and learning as much as possible about the facility and state systems. He recently obtained his board certification. The staff was comprised of the medical director, an advanced practice nurse (APRN), and a full time psychiatrist. The medical director and psychiatrist shared an office which provide opportunity for collaboration on medical-psychiatric issues. The APRN worked 8-16 hours per week. Her primary duties included completing annual medical summaries and assisting with sick call when necessary. A written collaborative practice agreement was in place, signed by the medical director and the APRN. The agreement followed the state-provided format. An effective date should be added t the agreement, either in the text, or alongside both signatures. A part-time physician position was vacant and a full time nurse practitioner was needed. The medical director carried the entire census as a caseload. The medical director assumed all on-call responsibilities from 11/1/10 until the week prior to the onsite visit. An advanced practice nurse had contracted with the facility to provide some call coverage. The whiteboard in the office of the medical director contained a list of his duties and his scheduled meetings that showed considerable overlap. When questioned by the monitoring team on the ability to perform all of these duties and provide clinical care for everyone at the facility, he reluctantly responded that it was difficult. He further expressed concern that he had not had an opportunity to complete a through review of all individuals in the facility and was concerned that there could be outstanding medical issues that needed follow-up. The medical department was staffed with an administrative assistant, one licensed vocational nurse, and three transporters. X-rays and labs were done at University Medical Center. Stat labs were completed within one to two hours and routine labs results returned within 24 hours. Wet readings of x-rays retuned with the individuals and the official reading was usually completed within 24 hours. These were acceptable timelines.	Noncompliance

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		Onsite clinics included neurology, psychiatry, and dental clinic. The neurologist held clinic once a month for approximately three hours. A joint neurology-psychiatry clinic was scheduled to occur the week after the onsite review. Dictations were completed by phone through a service that the medical director reported and a one-hour turn around time. This was a marked improvement over the previous process. Individuals came to the clinic for evaluation when possible and approximately 20 individuals were seen daily. Individuals who were in need of acute care were transferred to a local hospital. The medical director believed the relationships with local hospitals was even better due to his previous work as a hospitalist in the community hospitals. Individuals were referred out to the community for a variety of specialty appointments. When consultations were completed, the consultation form was routed to the clinic and placed in the in box for review by the medical director. The monitoring team requested documentation that described and summarized physician and medical staff participation in the PSP process, including attendance at PSP meetings. No documentation was submitted. Overall, however, staff across the facility, including the CNE and pharmacy director expressed that the medical director was a team player and was very participatory. This was evident to the monitoring team during observations and interviews onsite, as well as the in the multidisciplinary approach he led in the development of a number of clinical guideline protocols. The facility needs to consider that it would be difficult to expect the medical director to attend all PSPs and PSPAs with a caseload of 134 as well as his other responsibilities as the medical director. The record sample, listed above in the Steps Taken section of this report, was chosen using the following methodology: • Records were randomly selected from the various lists of individuals submitted by the facility. One record, individual #73, was selected due to the specific hospital diagnosis. • A request was made for all seizure clinic notes for the past six months. Notes on 10 individuals were provided. **General Medical Care and Documentation** <u>Annual Medical Assessments</u> Annual medical assessments were found in every chart reviewed. The assessments were	

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		completed within the required timeframes and were based on a standardized format. The documents provided detailed information related to the individual's health status. There were several summaries in the sample, however, that failed to include a diagnosis for which the individual received medication (Individual #23, Individual #6, Individual #10). The format of the annual medical assessment lacked a substantive summary of the active problems and plan of care. It also lacked documentation of the medical risks factors for each individual other than osteoporosis. Active Problem List Active problem lists were found in those records with annual assessments completed in the last four months. They included active problems, inactive problems, and past surgical procedures. They also included a section for updating the lists as problems changed. Active problem lists were not being used at the time of the last monitoring visit. The HCGs required this as a separate document, so this was good to see. The APLs were being implemented as the individual's annual assessments were being completed. This process began in late 2010. Integrated Progress Notes Notes were written in SOAP format, timed, and dated. There was frequent documentation in the records by the medical staff. When an acute problem arose, the medical staff documented the findings and the plan of care. There was increased documentation related to post hospital follow-up and quarterly summaries were present in a few charts. Physician Orders Given the large number of medications prescribed and orders written, the physician orders were compliant with the requirements set forth in the Health Care Guidelines. Although some incomplete and unclear orders were found in records, the issues were primarily related to start times for antibiotics, omission of medication strength, and lack of a medication stop date. Examples of these findings are included below in N1. **Routine and Preventive Care** 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	

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		information related to colonoscopy and pap dates, PSA levels, and osteoporosis. A preventive care flow sheet had been developed, but was not found in any of the records included in the sample.
		
		<u>Screenings</u>
		• 14 of 14 records contained documentation of appropriate vision and hearing screenings
		• 14 of 14 records contained documentation of either screening or diagnostic colonoscopies
		• 11 of 12 records documented screening for prostate cancer
		• 1 of 1 record documented screening for breast cancer
		
		<u>Immunizations</u>
		• There was evidence of compliance with guidelines for administration of Influenza, H1N1, and pneumococcal vaccinations.
		• Vaccination against varicella was not required and infrequently documented.
		• There was evidence of compliance with guidelines for administration of vaccination against Hepatitis B. Non-responders were not always clearly identified in the records.
		
		Medical Management
		
		<u>GERD</u>
		• 9 of 14 individuals were diagnosed with GERD
		• 8 of 9 individuals with GERD received appropriate medical therapy
		  o 1 of 9 individuals received the improper dosing frequency of reflux medication and the DRR contained recommendations for correction.
		
		<u>Osteoporosis</u>
		• 7 of 14 individuals had osteoporosis
		  o 4 of 7 individual were treated appropriately with calcium, Vitamin D, and Alendronate
		  o 2 of 7 individuals were treated with calcium and Vitamin D. Alendronate was not prescribed due to GI issues, however, there was no discussion of alternative treatments documented by the physician. The facility completed a DUE targeted at individuals who cannot tolerate traditional therapy.
		  o 1 of 7 individuals received adequate therapy with calcium, Vitamin D, and Raloxefine
		• 3 of 14 individuals had osteopenia	

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		o 2 of the 3 individuals received Alendronate , calcium, and Vitamin D. o 1 of the 3 individuals received calcium and Vitamin D supplementation. • 4 of 14 individuals had normal BMD. o All received calcium and Vitamin D supplementation. Hypothyroidism • 10 of 14 individuals had a diagnosis of hypothyroidism • 10 of 10 individuals received treatment with thyroid replacement hormone • 10 of 10 individuals had appropriate laboratory monitoring Diabetes Mellitus • 3 of 14 individuals had a diagnosis of diabetes mellitus • 2 of 3 individuals had persistently uncontrolled diabetes as evidenced by elevated HbA1c o Individual #113 received enteral meals, yet the nutritional review dated 9/13/10 did not address the HbA1c 8.6 (mean glucose 200) that was persistently elevated. o Individual #10 had a HbA1c of 7.8 and other inconsistencies in diabetes care, such as not receiving a renal protective dose of an ACE/ARB and missing an annual eye exam. • The clinical guidelines for management of diabetes provides standardization for this care. Bowel Management • 12 of 14 individuals had a diagnosis of constipation. • The average number of medications prescribed for constipation was three. • 3 individuals required four medications and one individual required 5 medications o All of these individuals had completed colonoscopies; none had any additional studies to assess colonic motility. • The policy and procedure, Constipation Prevention and Management Protocol, outlined the constipation risk assessment, defined the role of each team member, and provided guidance for treatment. Individuals with poor response were to be referred back to the medical clinic for evaluation. The policy remained in draft form at the time of the onsite review. Hypertension • 3 of 14 individuals had a diagnosis of hypertension • 3 of 3 individuals received appropriate monitoring of blood pressure and labs	

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		Cancer • One individual had been diagnosed with cancer in 2003, found as a result of routine PSA screening. The individual received treatment, was being monitored and was doing well. Hepatitis B • Two individuals were diagnosed as Hepatitis B carriers. This is an active problem that requires surveillance due to the risk of reactivation of the virus–return of HBeAg positivity. This risk should be discussed in the annual medical summary. Case Reviews • Individual #8 had medical diagnoses that included seizure disorder, diabetes mellitus, constipation, hypertension, hyperlipidemia, hypothyroidism, SIB, and hyponatremia. The individual received preventive care consistent with the facility's protocols including vision and hearing evaluations, and colonoscopy. The interval history included in the annual assessment dated 12/6/10 documented "hospitalization for severe delirium, abscess left hand, status post I&D, status post respiratory failure secondary to medications." The hospital summaries were not provided, so it was not clear if the medications were given at the hospital. The individual was followed in Neurology clinic and a recommendation was made on 10/27/10 to increase Carbatrol to 400 mg BID. The physician signed off on that recommendation, but no order was written to increase the medication. The Quarterly Medical Review was completed on 12/29/10 and noted the following: o The diagnosis of diabetes mellitus will be removed due to a lack of evidence to support the diagnosis. o The biopsy reports from the colonoscopy and EGD done in 6/2010 need follow-up. This case demonstrated a mix of findings: o Delivery of appropriate preventive care. o Failure to increase AEDs per neurology recommendation. o Failure to follow-up on diagnostics, such as biopsy reports. • Individual #102 had multiple medical problems, including seizure disorder, hypertension, osteopenia, deep venous thrombosis, and prostate cancer. The	

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		individual had received appropriate preventive care including vision and hearing screenings, immunizations, and colonoscopy. An adenomatous polyp was removed in 2009 during colonoscopy. Prostate cancer was diagnosed in 2003 through routine screening and was treated with radioactive implants. The individual was followed by urology and neurology. The individual received calcium, Vitamin D, and Alendronate for treatment of osteopenia. The last BMD done in 8/10 showed improvement in BMD and was read as normal. There had been good control of the individual's blood pressure and seizure disorder. He received regular dental care and had good oral hygiene. The individual ambulated independently and currently had an objective for self-administration of medication. This case highlighted the value of screenings and preventive care. This individual was diagnosed with prostate cancer and treated. The individual had a screening colonoscopy that resulted in removal of an adenomatous polyp – a polyp with the potential to become malignant. Aggressive treatment of osteopenia resulted in improved bone density. Overall, the PSP considered that he was doing well. • Individual #10 had the diagnoses of seizure disorder, diabetes mellitus, hyperlipidemia, hypertension, hearing impairment, and psychotic disorder. The annual assessment dated 2/10/10 included, in the discussion, a low risk for osteoporosis. The plan was to add calcium and Vitamin D and obtain a BMD study. The medication section of the same document listed Alendronate and calcium/Vitamin D as active medications. The individual had a BMD completed in 3/09 that showed osteoporosis. The most recent medication MAR did not list Alendronate as a medication. • The individual was diagnosed with pneumonia on 2/11/10 and was treated with antibiotics. The physician documentation on 2/22/10 revealed vital signs were T 98.4, HR 75, and POX 96%. There were inspiratory crackles on the lung exam. Ciprofloxin was prescribed and the individual was to follow-up in three days. On 2/25/10, the individual was seen by the physician who documented that DCS reported the individual did not look good today. Vital signs were BP 116/76, HR 100, RR 26, POX 89 -92%. The lungs had crackles and the patient appeared less active. Reactivation of TB was considered due to progression of airspace disease on the CXR. A CT was requested and the individual was placed on respiratory isolation. The individual was noted to be lethargic several hours later and was transferred to the local hospital where he was diagnosed with a pulmonary embolism. The individual returned on 3/5/10 and was seen by the physician on 3/8/10. The post hospital assessment did not include any discussion related to	

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		increased risk of thromboembolism in this 61-year-old ambulatory male or what factors may have contributed to his increased risk. The individual had been recently diagnosed with pneumonia. The lung exam was not particularly abnormal, but not documented as clear. He was scheduled to have follow-up in three days, but follow-up the next day would have been more appropriate because of the history of recent pneumonia. On day three, it was obvious that clinical decompensation had occurred based on the increased HR, increased RR , decreased POX, and change in mental alertness. The individual was ambulatory and had a pulmonary embolism. There was no discussion of the origination of the clot or if the individual had a work-up for hypercoaguable states. These factors determine long-term treatment and risk for recurrent thrombotic events. • Individual #74 was reported to have emesis on 2/11/10. Nursing documented BP 118/82, HR 72, and RR 18. The abdomen was reported to be soft and non-tender. The individual had a bowel movement earlier that day. On 2/15/10, nursing documentation at 8:00 am indicated that the individual was hypotensive, but no signs or symptoms of distress were noted. The plan was to continue to monitor. At 9:00 am, Tylenol was given for a temperature of 100.1. The nurse documented BP 150/88, RR 24, and HR 108. The plan was to monitor. At 12:00 noon, the nursing entry noted a temperature of 98.9. The individual was in no distress and was placed on the clinic schedule for 2/16/10. A subsequent entry on 2/15/10 documented that the doctor was called and he requested vital signs be taken by a registered nurse. On 2/16/10, the advanced practice nurse evaluated the individual and noted that there were crackles at the lung base and abdominal distention. The individual was transported for an outpatient CXR and KUB and was subsequently admitted for pneumonia and pneumoperitoneum. Upon return to the facility on 2/22/10, the physician evaluated the individual. The post hospital note did not provide any information relative to the risk of aspiration as an etiology of the pneumonia. This was in spite of the fact that the individual had a history of emesis and abdominal distention. On 2/23/10, the SLP reported some swallowing difficulties during bedside evaluation. At that point, the individual was considered to be at risk for aspiration secondary to dysphagia. On 5/30/10, the individual was noted to limp. The MD assessed the individual that day and noted contusions to the breast and shoulder with an unconfirmed gait abnormality. On 6/1/10, the DCS reported that the individual had urinary incontinence and refused to get out of bed. A white substance was reported to be in the urine and coating the tongue. Vital signs were documented as BP 121/64, T 98.8, P 84, RR 20, and POX 92%.	

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		The individual cried with palpation of the right hip. The plan was to monitor. The individual was seen by physical therapy on that same day and noted that the individual refused to walk. "PT will await MD orders and recommendations." The MD assessment on 6/2/10 noted expiratory wheezing and vital signs were HR 89, T 101.4, and POX 84%. The individual was transported to the hospital by EMS and admitted with a diagnosis of aspiration pneumonia and UTI. Upon return to EPSSLC, the individual was assessed by the MD who documented that the hospital SLP had made recommendations for feeding in the upright position. Those recommendations were to continue and an SLP consult was requested. The individual continued to have a limp and evidence of right hip/leg pain. Medical entries on 6/8/10 and 6/14/10 again documented unconfirmed gait abnormality and osteoarthritis, but no exam findings are noted in the record. The individual was sent for a Doppler ultrasound on 6/13/10 due to leg and ankle swelling. The ultrasound was negative for deep venous thrombosis. The individual was evaluated by another MD on 6/14/10 who elected to treat the individual for DVT and perform additional studies based on the clinical suspicion. On 6/16/10, the individual had repeat Doppler studies that returned the critical finding of deep venous thrombosis of the right peroneal vein. A quarterly medical summary was completed on 12/31/10. The review of this individual's care required to complete the summary resulted in numerous care issues being identified: o Valium was prescribed as treatment for a movement disorder. o Medications were contributing to hyponatremia. o The patient had a diagnosis of reflux but received no treatment. o The individual was referred back to urology to address the issue of urinary retention since meds contributing to this were being decreased. o The left hip x-ray showed an abnormality that required follow-up o There was a surgical consult in January 2009 for a left back mass. The individual had an ultrasound done that indicated a likely lipoma. The surgical follow-up did not occur. This case demonstrated that: o The nurse should have notified the physician of fever. o The post hospital assessment by the physician should have included discussion related to the risk of aspiration given the clinical findings. o Physician documentation repeated unconfirmed gait abnormality in spite of the fact that there was evidence that the individual would not get out of bed and walk, an activity that normally occurred. o The quarterly summary highlighted both positive and problematic aspects of care.	

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		Emergency Medical Care The facility maintained a system of responding to medical emergencies and employees were required to have current CPR training. Mock drills were conducted. The medical director was not familiar with how this process was carried out. He was not aware of any oversight committee for the medical emergency response system. During discussion with the chief nursing executive, she reported that the medical emergency response system was under the direction of Risk Management because that department conducted the drills. Competency Training and Development conducted training. There were four AEDs on campus and they were checked by the nursing department. The nursing department also maintained respiratory equipment, such as bag valve masks. The IT Department completed AED software updates. A review of the drill documents indicated that drills were being conducted, but not at the required frequency. While a drill checklist was utilized, there was no standardized recording form for an actual Code Blue. This made documentation of Code Blue events difficult since exact time of events must be recorded. **Seizure Management** The document request contained a spreadsheet of the individuals with seizure disorder, the type of seizure, and the medication regimen. Instead, the data given to the monitoring team appeared to have been generated by the pharmacy department; it was a list of 81 individuals who received anticonvulsant medications. A request was made for copies of all seizure clinic notes for the past six months. Seizure clinic notes were received for 10 individuals for a total of 28 notes. Clinic was held once a month for approximately three hours during which time approximately 10 individuals were seen. A comparison of the seizure clinic notes to the pharmacy database indicated that some patients seen in seizure clinic were not included in the database and the database did not have current drugs for some of the individuals seen in clinic. The date of 12/7/09 was noted in small print, possibly indicating this was the last update of the data. During the July 2010 onsite review, the pharmacy director indicated that the database had not been updated since 3/09.	

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		During discussion with the neurologist, he reported that the visits were focused on review of seizure data and a brief assessment of the individual. Neurology hours were going to be increased by having a combined neurology-psychiatry clinic once a month for approximately three to four hours. That clinic was scheduled to begin the week after the onsite review. In the clinic records reviewed, one individual had a vagus nerve stimulator implanted, five individuals had refractory or intractable epilepsy, three had controlled seizures, and one had a history of seizures. There was no discussion of consideration of VNS placement for any of the individuals with refractory disease. The clinic notes were brief, but all indicated the following: • Last clinic visit • Review of medication profile • AED therapy • Review of seizure records • Review of labs and AED drug levels • General appearance of individual (level of alertness, interaction and grooming) • Assessment and plan o Drug changes were done slowly and specific instructions for titrations were usually given. Information from the side effect rating tools did not appear in any of the notes. Overall, seizure management at EPSSLC was fair. The clinic notes provided to the monitoring team did not show documentation of consideration of more aggressive management of individuals with refractory seizure disorder. The notes provided were limited (only 28), and the database had not been updated since 2009 rendering the data too old to determine current medication management (e.g., number of individuals on two, three, four, five, and so forth drugs). Overall assessment of the seizure management requires that more information on outcomes and medication use be tracked and provided, including: • Number of persons on older drugs versus new drugs • Number of persons on 2, 3, 4, or 5 drugs • Number of persons with refractory seizure disorder. • The number of persons with refractory seizure disorder who have been evaluated for VNS The nursing department continued to provide initial training on seizure management to all direct care professionals.	

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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.	There had not been any medical review by a non-facility physician. Mortality Reviews were another type of case review completed by the facility. The system 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. There were five deaths recorded in 2010. The average age of death was 46 years. The causes of the deaths in 2010 were listed as: • Bacterial pneumonia • Cardiac dysrthymia • Bilateral pulmonary embolism, acute bronchopneumonia and aspiration pneumonitis (death certificate) • Coronary artery disease (death certificate) • Acute on chronic respiratory failure (death certificate) o Bilateral pulmonary thromboembolism with pulmonary infarction (autopsy) All of the mortality documents for deaths occurring since July 2010 were reviewed. The records of two cases were also reviewed. Documents for the three deaths were provided to the monitoring team for review and included the physician death summaries, QA nursing summaries, clinical death reviews, and death certificates and autopsy reports. The Clinical Death Review Committee met on Thursday 12/16/10 to review the three deaths that occurred since July 2010. The report documented the members in attendance: • Eugenio Chavez-Rice, MD – Chairman • Salvador Molina, DO, Attending Physician • Julie Graves Moy, MD, Medical Director, DADS • Mary Stohr – QA Director • May Ann Clark, RN – Nurse Operations Officer • Elaine Lichter, RN – QA Nurse There was no documentation of participation by an external physician. There was also	Noncompliance

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		no documentation of attempts to locate an external participant as required by DADS policy. The Clinical Death Review Committee determined, in all three cases, that there was no evidence of abuse or neglect and patient care was within acceptable standards. Case #1 Individual with multiple medical problems was hospitalized from 7/7/10 to 7/10/10 with pneumonia. The physician assessment on 7/12/10 indicated to continue current treatment. The individual was seen frequently over subsequent days for various complaints. On 7/21/10, nursing notes documented that the individual was alert and awake with BP 100/52, HR 101, RR T 97.5, and POX 95% on 2l NC. A medical assessment was done on 7/21/10 at 10:15 am due to drainage a G-tube site. It was documented that the individual was lethargic and vital signs were BP 100/60, HR 101, and RR 28. Rales were heard at the lung bases. Oxygen was increased to 3l NC. Stat labs and a CXR were ordered. The individual was scheduled for follow-up the next day. Nursing alerted the clinic that the individual appeared lethargic. Around 1:00 pm, critical labs (K 8.5 and BUN 149) were called in to the facility and a verbal order was given to transfer the individual to the hospital. The individual was seen by the medical staff at approximately 1:20 pm and was in no distress. POX was 88% on 3l NC with a HR 85. While awaiting the arrival of EMS, the individual suffered cardiopulmonary arrest. CPR was initiated and the individual was transferred to the hospital at 1:45 pm. The individual was pronounced dead at 2: 22 pm. Diagnosis was bilateral pulmonary embolism, acute bronchopneumonia, and aspiration pneumonitis. Findings of the clinical death review committee: • Abuse or Neglect – none • Changes in policy and procedures – None • Professional education – Embolism implement policy ASAP • Patient care – Ill, prolonging it. • Other – Committee agreed with the certificate of death diagnosis of bilateral pulmonary embolism, acute bronchopneumonia and aspiration pneumonitis The QA Improvement Death Review of Nursing Services provided a detailed review of the care of this individual. There were numerous recommendations following the conclusion of the report. Many of them pertained to very specific nursing interventions. Others involved issues related to systems of the facility, such as the medical emergency response system and tracking of physicians orders to ensure appropriate implementation. Within the context of the findings of the review, these were appropriate recommendations. The QA review was completed prior to the clinical death review. The	

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		clinical death review, as noted above, did not include any of the QA recommendations. Further, there was no documentation from the meeting to indicate that the QA recommendations were discussed and how the determination to not consider them was made. Furthermore, at the time of the onsite monitoring review, there had been no administrative death review. This individual was chronically ill with multiple medical problems. There was ample evidence of clinical deterioration on the morning of 7/21/10 based on the newly developed lethargy, increased respiratory rate, and the drop from the baseline oxygen saturation to 87%. It is doubtful that the ultimate outcome would have differed, but the most appropriate action in this situation would have been to transfer immediately to an acute care facility. <u>Case #2</u> This individual had a history of seizure disorder, cerebral palsy, and osteoporosis, and was administered Choral hydrate 500 mg po, Ativan 2 mg IM, and Benadryl 100 mg IM for pretreatment sedation prior to a community dental appointment. The individual arrived at the dental office around 7:00 am. At approximately 8:44 am, he was transported by EMS to a local medical facility where he was admitted to the intensive care unit and required mechanical ventilation. It appeared that the individual had respiratory problems at the dental office. Investigations were ongoing at the time of the onsite review. A complicated hospital course was followed by several months of treatment at a long-term acute care facility and a subsequent return to EPSSLC. Over the next two months, the individual had a series of acute illnesses. The individual expired approximately four months after the initial event. The death certificate cited coronary artery disease as the cause of death. The family declined autopsy. Findings of the clinical death review committee: • Abuse or Neglect – none • Changes in policy and procedures – Training for staff • Professional education –Await dental boards • Other – Committee did not agree with the certificate of death diagnosis of coronary artery disease and atherosclerosis, it needed to include more information. Recommendation made to add chronic acute respiratory failure and anoxic brain injury.	

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		The QA Death Review of Nursing Services included some recommendations, such as re-training on the significance of health status assessment prior to the individual's departure to medical appointments. The clinical death listed training as a recommendations, but the specific training required was not documented. Again, at the time of the onsite review, there had been no administrative death review for this case either. Mortality Review Management at EPSSLC The monitoring team discussed the mortality review process with the medical director and chief nurse executive. There were significant delays in the clinical death reviews of all three cases. Two cases were reviewed five months after death and the third one was reviewed three months after the date of death. The requirement, as noted above, was that the committee meet within 14 days and issue a report within 21 days after that. The medical director reported that he really was not aware of his role in the process and the timelines required by DADS policy. He was not clear on how the recommendations were accepted, implemented, and followed to completion. The administrative death reviews had not been scheduled. The facility administrator bears the responsibility of overseeing the process and needs to do so at EPSSLC. The chief nursing executive was questioned regarding the process of accepting and implementing recommendations. She reported that the QA Nurse worked independent from nursing and that the recommendations generated from that report were often not valid. Furthermore, the QA nurse was not aware of actions taken by the nursing department in response to her report. Perhaps some QA recommendations were not appropriate or applicable because, for example, nursing may have already implemented corrective actions making additional actions unnecessary. Either way, this lack of collaboration was a serious problem in the operation of this important function at EPSSLC. In addition, documentation of examples of corrective actions from previous mortality reviews was requested by the monitoring team. The CNE, however, reported that there was no corrective action or recommendations log that was maintained for this purpose. In a brief discussion with the CNE and state office nursing services coordinator, the monitoring team suggested that a mortality recommendations log be implemented in order to track recommendations to completion.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two	The facility did not have a formal procedure in place to comply with this requirement. The medical director continued to use the database to track key information, such a colonoscopies, mammograms, and pap smears. That information did not appear to be	Noncompliance

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	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.	used as any part of a medical quality review system.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	This provision item referred to the Health Care Guidelines that provided the framework for the standards of medical care to be provided by the facility. Also, DADS Policy #009: Medical Care was issued in July 2010. The medical director provided several clinical guidelines that were developed by an interdisciplinary group. He reported that the guidelines had been reviewed by state office, but had not been formally approved and implemented. The following guidelines were provided for review: • Diabetes type II • Metabolic syndrome • Coumadin management • Venous Thromboembolism Prophylaxis • Bowel Management Policy • Insulin protocols • Warfarin protocols • Osteoporosis risk assessment • Preventive Care Flow Sheet The guidelines were thorough and based on current standards, but were not always consistent with the proposed standards from DADS state office. The preventive care flow sheet added some necessary recommendations, such as administration of the varicella vaccination.	Noncompliance

Recommendations:

1. The facility must address medical staffing. The medical director should not assume the primary care responsibilities of a caseload. A second full time physician is needed. If that is not possible, a full time advanced practice nurse and part time physician will be needed. The medical director must focus on developing guidelines, policy and procedure and other initiatives associated with the Settlement Agreement.

2. The facility needs to determine how the medical staff will participate in the PST process.

3. The guidelines and pathways should be finalized, approved, and implemented. The development of a medical quality program is contingent upon implementation of guidelines that define the desired outcomes. Those tools that focus on risk assessment must be consistent with the agency's health risk initiatives.

4. The medical department must develop a comprehensive database to track preventative care and key elements related to medical quality.

5. The facility should approach the correction of the mortality review system with a sense of urgency. The role and responsibility of each committee member should be clearly defined by the facility director. External reviewers should be sought and reviews should be completed within the specified timeframes. Discussions related to recommendations should be documented. There should be a clear rational for rejecting the recommendations and that should be documented. When recommendations are accepted, a corrective action plan should be developed that specifies the issue, action steps required, responsible persons, and timelines for completion.

6. The facility should continue to pursue the services of an external physician reviewer as required by he Settlement Agreement. The possibility of using a faculty member of a local medical school should be explored.

7. The medical staff should continue to complete quarterly summaries as this process provides valuable information.

8. Consultation forms should be appropriately completed instead of requesting "eval." The form should specify the issue to be addressed and adequate information should be provided to the consultant. The date of consult request should be included in the space provided on the form.

9. Data from the clinic tracking system should be used to determine if timeframes for consultations are being met. The referring physician should specify the timeframe for the appointment. If an appointment cannot be secured within that period, the physician should be notified so that appropriate action can be taken. The medical director should review these data on a regular basis and take corrective action as needed.

10. The medical department should create a seizure database. Medications used for the treatment of a seizure disorder should be entered into the database and updated as changes are made. Other data elements including the dates of seizures, and the number of medications prescribed should also be entered. This information would improve efficiency of neurology clinic and is also needed to determine the quality of the seizure management program.

11. Consideration should be given to standardizing the neurology clinic notes to ensure inclusion of the side effect rating tool information and assessment of the impact of multiple drugs on quality of life.

12. Improve emergency drills to meet required frequency and content.

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 EPSSLC Organizational Chart o Map of EPSSLC o DADS State Supported Living Center Policy: Nursing Services (1/31/10) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o A list of all individuals served by residence/home, including for each home an alphabetized list of individuals served, their age (or date of birth), date of admission, and legal status o A list of individuals admitted within the last six months and dates of admission o The agenda for new staff orientation o The curricula for new staff orientation, including training materials used o The schedule for ongoing in-service staff training o The curricula for ongoing in-service staff training, including training materials used o For nursing, 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; and the current FTE o Lists identifying each individual who is identified to be "at risk" utilizing the state's risk categories o For the past year, individuals who have been seen in the ER, including date seen and reason for visit o For the past year, individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), and date of discharge from hospital o For the past six months, individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial); and/or have had a swallowing incident, including the date of incident, item that caused the swallowing incident, and the interventions following the incident o For the past three months, Health Status Team Meeting minutes o Nursing staffing reports/analysis generated in the last six months o Minutes of the Infection Control Committee for the last six months o Minutes of the Environmental/Safety Committee for the last six months o Minutes of the Department of Nursing meetings for the last six months o Minutes of the Nutrition Management Committee for the last six months o Minutes of the Pharmacy and Therapeutics Committee meetings for the last six months o Minutes of the Medication Performance Improvement Team meetings for the last six months o All EPSSLC policies and procedures addressing emergency/code blue drills o EPSSLC training curriculum for the implementation of emergency procedures including training materials

	o All emergency/code blue drills, medical emergency reports, including tracking logs, recommendations, and/or corrective actions based on these reports/analyses for the last six months o List of EPSSLC staff who were certified in first aid, CPR, or ACLS with expired certification o Documentation of annual consideration or resuming oral intake for each EPSSLC individual receiving enteral nutrition o All EPSSLC training curricula on infection control, including training materials o EPSSLC infection control surveillance and monitoring reports for the last six months o EPSSLC nursing audits, data, analysis reports for the last six months o EPSSLC medication administration audits and reports for the last six months o For the past six months, list of individual who died at EPSSLC or after being transferred to a hospital or other care setting o For the past six months, mortality reviews and recommendations prepared by the QA Department o EPSSLC Self-Assessment: POI 2010 o EPSSLC Meeting Schedule updated 1/2/11, updated o Records and MARs of: • Individual #4, Individual #92, Individual #11, Individual #71, Individual #113, Individual #6, Individual #93, Individual #32, Individual #178, Individual #75, Individual #195, Individual #188, Individual #73, Individual #126, Individual #108, Individual #33, Individual #116, Individual #38, Individual #81, Individual #60, Individual #102, Individual #107, Individual #78, and Individual #51 Interviews and Meetings Held: o Opening meeting on EPSSLC progress since baseline review o Chief Nurse Executive, Sandy DeLong, RN o Nurse Operations Officer, Mary Ann Clark, RN o Quality Enhancement Nurse, Elaine Lichter o Infection Control Nurse, John Chea, RN o Nurse Recruiter, Neda Daniels, RN o Pharmacy Director, Amista Salcido, Pharm.D. o Nurse Manager, Cynthia Diaz, RN o Nurse Supervisor (in transition to Nurse Manager), Veronica Bahner, RN o Nurse Case Managers, Vicenta Casillas, RN, and Phillip Bueno o Risk Assessment Review Meeting, Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator Observations Conducted: o Visited individuals residing in Dorms A, B, and C, 508, 509, 510, 511, 513, 510, and 516 o Medication administration in Dorms A, B, and C, 508, 509, 510, and 513 o Enteral feedings in Dorm C and 513 o PSP Meeting (Individual #43)

	Facility Self-Assessment: The facility's self-assessment for section M, the POI, indicated that many initiatives were in the early or initial stages of development and/or awaiting further direction through policy and procedure development and revision at the state level before proceeding. Thus, the facility self-rated noncompliance for all items. The monitoring team concurred with these self-ratings.
	Summary of Monitor's Assessment: As noted during the prior monitoring review, the EPSSLC nurses were diligently working in the midst of changes and challenges, which included the loss of several nursing management staff members. As of the current monitoring review, the positions of Nurse Liaison, Nurse Educator, Campus Nurse Supervisor, and Nurse Manager positions were vacant. These vacancies had a significant negative effect on the facility's ability to make progress toward substantial compliance with provision items M1 – M6 of the Settlement Agreement. As noted below, numerous problems, were identified in the areas of nursing assessment and reporting. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not yet evident during the onsite review and in the 20 records reviewed. Notwithstanding the changes and challenges, the Nursing Department participated in activities to improve practices. They provided the facility's nurses with re-training and re-education in documentation of progress notes, assessments, and care plans. In addition, during late Summer, the Nursing Department changed the format of the Individual Progress Notes (IPNs) from DAP (data, assessment, and plan) to SOAP (subjective and objective data, assessment, and plan) format. Nonetheless, a review of individuals' records revealed that since the prior review, the legibility of nurses' notes, signatures, and credentials had declined. Also, although the Nursing Department reported that all nurses were re-educated regarding the conduct of shift-to-shift report and the Department's expectations for documentation of an informative 24-hour shift report, these processes, as observed, continued to need improvement in order to become a reliable method of communicating individuals' significant changes in health status from one shift to the next. Quarterly and annual nursing assessments existed in each of the 20 sample individuals' records, but the majority of the sample individuals did not have accurate, complete, comprehensive assessments that resulted in complete lists of nursing diagnoses, such that care plans/interventions could be properly developed and/or updated. There were also many individuals who suffered significant changes in their health status between quarterly assessment periods (e.g., hospitalizations, serious illnesses, and injuries affecting health status, functioning, and overall health and well-being) whose assessments were not updated in accordance with the provisions of the Settlement Agreement and Health Care Guidelines. All 20 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and Acute Care Plans (ACPs). There were significant problems noted in the HMPs and ACPs, that were largely due to the persistent pattern of failure to: (1) incorporate all relevant data from systems' assessments into the HMPs and ACPs, (2) reference all health risks and actual problems in the HMPs and ACPs, and (3) update HMPs and ACPs as needed to ensure they addressed all current health needs at all

	times. The CNE and NOO acknowledged that continued improvement was needed in all areas of nursing care. They, and other members of nursing leadership, reported that attitudes were more positive, staffing levels and coverage have improved, interdisciplinary collaboration was occurring, and the nursing management group had come together as a team. Thus, they were confident that some improvements had been made, and that the achievement of some steps toward compliance with some of the provision items was on the horizon.

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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.	In the prior monitoring review, it was noted that EPSSLC was making progress toward meeting this provision item. Although EPSSLC has continued to articulate a commitment to improve performance and achieve compliance with this provision of the Settlement Agreement, since the prior monitoring review, little progress has been made toward meeting this provision item. Thus, due to the persistent pattern of absence of consistent identification of health care problems, incomplete assessments, failure to implement interventions, and lacking appropriate follow-up to resolution, a rating of noncompliance was made. During the conduct of this onsite monitoring review, nine nurses were interviewed, 20 individuals' records were reviewed, and 16 of the 20 sample individuals were visited on their residential units. The facility should be commended for its recent reorganization of all individuals' records and significant improvements in recordkeeping practices. The Nursing Department also participated in activities to improve recordkeeping practices and had provided the facility's nurses with re-training and re-education in documentation of progress notes, assessments, and care plans. In addition, during late Summer, the Nursing Department changed the format of the Individual Progress Notes (IPNs) from DAP (data, assessment, and plan) to SOAP (subjective and objective data, assessment, and plan) format. Notwithstanding these positive findings, the review of individuals' records revealed that since the prior review, the legibility of nurses' notes, signatures, and credentials had declined. Also, across all records reviewed, it was evident that although most nurses had changed the documentation of their notes from DAP to SOAP format, they had not changed their practice to ensure that their notes accurately referenced that they had gathered subjective and objective data, conducted a complete assessment, and formulated a thoughtful plan to appropriately address the matter at hand. As noted in the prior review, across the 20 individuals' reviewed, there was evidence that	Noncompliance

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		the nurses usually notified the individuals' physician of changes in the individuals' health status and needs in a timely manner. There was also evidence that once notified and/or "put on the clinic list," the physician or nurse practitioner saw the individual within 24 hours or less depending on the circumstances. Contrary to the prior review, however, it was noted that individuals' direct care staff members had not consistently notified the individuals' nurses in a timely manner of significant changes in the individuals' health status and needs. There were also many occasions when the first reference to a significant change in an individual's health status was documented by the individual's physician and/or nurse practitioner in reference to the individual's visit to the medical clinic. Thus, there were delays in the assessment and treatment of individuals' health needs and risks. Also, although the Nursing Department reported that all nurses were re-educated regarding the conduct of shift-to-shift report and the Department's expectations for documentation of an informative 24-hour shift report, these processes, as observed, continued to need improvement in order to become a reliable method of communicating individuals' significant changes in health status from one shift to the next. During the monitoring team's observations at changes of shift, it was noted that nurses did not consistently review the written shift reports, and they did not receive adequate verbal reports of individuals' health status. Information exchanged at the changes of shift varied across residential areas and among nurses - some nurses availed themselves of every opportunity to exchange and receive information, but the majority did not. According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. As noted in the prior review, comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Across all 20 sample individuals' reviewed, documentation of IPNs failed to provide evidence that nurses were consistently identifying health problems and significant changes in status, adequately intervening, and appropriate recording follow-up to resolution. Numerous examples from this sample indicated the seriousness of this problem at EPSSLC and extended to all phases of the nursing process from assessment to evaluation of plan effectiveness. • On 10/25/10, Individual #33's physician noted that he conducted a follow-up examination of the "nodule [in Individual #33's] left axilla [armpit]." According to Individual #33's physician's report, he found that there were no changes in	

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		the nodule since he examined it on 9/15/10. Notably, during the period immediately preceding 9/15/10, and during the period of 9/15/10 – 10/25/10, there was no evidence that Individual #33's nurses' had identified or monitored the nodule for changes. In addition, from 10/25/10 – present, there was no evidence that his nurses' monitored the nodule for changes, such as inflammation, secondary infection, trauma, and chronic irritation. During the conduct of the review, the monitoring team learned that Individual #33's physician had referred him to a surgeon who diagnosed the nodule as an "inclusion cyst of the left axilla," and he/she recommended that it should be "monitored for now." • Individual #51 was a 45-year-old man that was prescribed multiple psychotropic and other medications that could cause metabolic side effects. On 10/16/10, Individual #51's direct care staff member reported to his nurse that he had "gotten up to void outside (emphasis added) five times and is voiding very little when he does." Individual #51's nurse obtained a set of vital signs, albeit incomplete, and noted, "[Individual #51 is] smiling, sitting down. No restlessness noted. Dr. notified – orders. Will monitor individual for discomfort." Indeed, upon notification, Individual #51's doctor ordered that his intake and output should be monitored., however, there was no evidence of further assessment or monitoring of Individual #51's condition by his nurses, and no evidence that his intake and output were monitored and recorded, as ordered by his physician. Two days later, Individual #51's physician ordered a urinalysis and a follow-up appointment at the medical clinic to rule-out a urinary tract infection. • On 11/20/10, Individual #51's nurse noted that his direct care staff member reported, "While she was showering Individual #51 she discovered a U-shaped redness on his back." Individual #51's nurse noted that the redness measured 20 cm long and 5 cm wide, which covered most of Individual #51's back. Individual #51's nurse's assessment was limited to - "No signs of distress noted" and his/her plan was - "Will continue to monitor." There was no evidence that his nurse made any attempt to assess whether or not he had suffered a first-degree burn, no complete evaluation of the "redness," and no implementation of any intervention to address his alteration in skin integrity. In addition, there was no evidence that, at the very least, Individual #51's nurse checked the water temperature in the shower to ensure that it did not exceed 110 degrees, in accordance with ICFMR regulations, to help protect the individuals from harm. • On 12/1/10, Individual #51's direct care staff member reported to his nurse that he had coughing and congestion. Individual #51's nurse failed to conduct an assessment of Individual #51 and only obtained an incomplete set of vital signs. Although Individual #51's nurse indicated that there would be monitoring of him	

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		through the night, there was no evidence of monitoring or follow-up assessment of his significant change in health status by his nurses. • Individual #93 was a medically fragile 54-year-old woman. She was diagnosed with cerebral palsy, quadriplegia, contractures, osteoporosis, GERD, constipation, and history of multiple infections including upper respiratory and urinary tract infections and aspiration pneumonia. Over the past year, she had suffered frequent injuries and weight loss. On 10/11/10, Individual #93 was hospitalized for treatment of tachycardia, cough, and fever. She was diagnosed with urosepsis and treated with antibiotics and monitored by telemetry. Individual #93 returned to the facility on 10/20/10. There was no evidence that Individual #93's nurses conducted an assessment once a shift, or more often, to ensure that Individual #93 was stable upon her return from the hospital. In addition, during the immediate 72-hour period post-hospitalization, there was only one nursing assessment that included a complete set of vital signs and an evaluation of Individual #93's systems. • On 11/4/10, Individual #93's nurse practitioner examined a "blister" on her heel. The nurse practitioner noted that the blister-like lesion on Individual #93's left heel appeared to be from friction from her wheelchair. The nurse practitioner ordered application of triple antibiotic ointment and observation. There was no evidence of Individual #93's nurses' assessment and monitoring of her alteration in skin integrity. Notably, one of the nursing interventions referenced in Individual #93's HMP related to alteration in skin integrity indicated that "any breaks in the skin [requires] document daily or until skin issue resolves." • Individual #71 had a history of open wounds, abrasions, and other alterations in skin integrity. On 10/8/10, Individual #71's physician noted that he had an outbreak of seborrhea dermatitis on his face and scalp with multiple scratches and skin lesions on his scalp. Individual #71 was prescribed twice daily applications of an anti-fungal topical cream for the next four weeks. Individual #71's nurses failed to conduct at least daily assessments of his alteration in skin integrity. Rather, during the period of 10/8/10-10/22/10, Individual #71's nurses documented on only two occasions that his scalp and face were "Still dry and flaking" (10/12/10) and "Dry skin noted throughout [Individual #71's] face" (10/16/10). • On 9/21/10, Individual #108's physician evaluated her in the medical clinic for symptoms of nasal congestion. Individual #108's physician diagnosed her with an upper respiratory infection and indicated that she was not to attend programs, groups, or workshop for the next three days. Individual #108's nurses failed to conduct follow-up assessments of her change in health status. Thus, there was no evidence of oversight of Individual #108's response to	

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		prescribed treatment and evaluation of her need for administration of standing medication to treat her cold symptoms, as ordered by her physician. • On 9/30/10, Individual #108 was found with a 3 cm abrasion on her left knee and a 4 cm x 4 cm brown discoloration of her left elbow. According to Individual #108's nurse's note, she was "aggressive and unsteady and was hitting her table at dinner last night, which may be the cause [of her abrasion and discoloration.]" Individual #108's vital signs were obtained, but there was no evidence of a complete assessment of Individual #108's extremities, including an evaluation of presence of pain, swelling, range of motion, etc. Rather, Individual #108's nurse precipitously concluded, "No signs/symptoms of distress noted. Will continue to monitor." There was no evidence that Individual #108's nurses conducted follow-up assessments or monitoring of her injuries. • Individual #60 was a 66-year-old woman diagnosed with dysthymic disorder, moderate mental retardation, seizure disorder, obesity, elevated triglycerides, osteoporosis, lymphedema, GERD, constipation, and hypokalemia. During the 10½-week period of 9/29/10-12/12/10, Individual #60 fell five times. On all five occasions, Individual #60's nurses failed to document complete assessments of her when she fell, and they failed to consistently conduct and document post-fall assessments and monitoring, including, but not limited to, conducting and documenting complete Head Injury Protocols (HIPs). This was especially detrimental to Individual #60, who suffered a rib contusion during one of these falls. There was no evidence that Individual #60's nurses ensured that her physician's orders for use of the incentive spirometer, daily ambulation, and adequate pain management to promote adequate expansion of her lungs were carried out or that she was closely monitored for cough and/or abnormal lung sounds. Four days post-fall, Individual #60 developed a cough and congestion. • Individual #78 was a 32-year-old woman diagnosed with a host of medical problems that included gastrointestinal disorders such as hiatal hernia, GERD, erosive gastritis, and constipation. During a 50-day period (8/28/10-9/29/10 and 12/9/10-12/28/10), Individual #78 had 10 documented episodes of vomiting, usually large amounts of undigested food and sometimes medications, after eating. On not one of these occasions did Individual #78's nurses document a complete assessment of her and/or conduct timely follow-up assessments and monitoring of her to ensure that she had not experienced an untoward outcome of the episode(s) of vomiting. Notably, after at least three of the 10 vomiting episodes, Individual #78's nurses noted, "[She] had a cough…looks sad," "was coughing and brining up thick yellowish phlegm," and "moist cough audible occasionally." But, as noted above, despite the presence of a possible sign/symptom of aspiration pneumonia, vigilant assessment and monitoring failed to occur.	

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		• On 11/3/10, Individual #78's direct care staff reported that she fell. Individual #78's nurse noted that she was "awake and alert" and that a "body check" revealed "no injury at this time" and that her "gait unsteady [which is] usual for [her]." Individual #78's nurse failed to document a complete assessment of her or conduct follow-up monitoring to ensure that she had not sustained an injury from her fall. • On 11/8/10, Individual #188's PPD converted from non-reactivity to reactivity. On 11/9/10, Individual #188's nurse noted that she could not go on an outing due to "positive PPD reading." On 11/10/10, Individual #188's physician noted, "PPD + 20 mm, conversion." Despite the fact that conversion from non-reactivity to reactivity to immune challenge by PPD is presumptive evidence of active TB unless proven otherwise, there were no assessments documented by Individual #188's nurses of this significant change in her health status. On 11/15/10, the facility's Infection Control department briefly referenced that an assessment had occurred at some time, and it revealed "no respiratory distress, no productive coughing, and no fever at this time." But, no vital signs were documented, and there was no evidence of a complete evaluation of Individual #188's health status and functioning, including, but not limited to an assessment of the status and functioning of her respiratory system. In addition, although on 11/27/10 Individual #188 developed nasal drainage and was "put on the clinic list," there continued to be no evidence of a complete assessment of Individual #188 by her nurses. On 12/1/10, Individual #188's direct care staff member reported to her nurse that she was also coughing. At this time, a complete set of vital signs was finally obtained, Tylenol 1000 mg was administered, and Individual #188 was "to be seen at the clinic." • During the period of 9/17/10-1/4/11, Individual #102 suffered eight skin infections, some of which were accompanied by intense itching and scratching, rash, and macerated skin. Although there was ample evidence that Individual #102's nurses knew of his significant changes in skin integrity, on not one of the eight occasions of altered skin integrity was there evidence of an initial complete assessment and follow-up assessment and monitoring by his nurses. • On 9/2/10, Individual #81 was evaluated in the medical clinic for injuries sustained during a behavioral outburst. Individual #81 had a swollen right eye and injuries (i.e., open wounds, to his fingers). Individual #81's physician prescribed application of triple antibiotic ointment to his finger wounds three times a day for seven days. There were no nurses' assessments of Individual #81's wounds or evaluations of his progress/lack of progress toward healing without infection prior to his return to the medical clinic one week later. • On 8/30/10, Individual #107 was seen in the medical clinic after the wheel broke off of his wheelchair and he fell out of the chair. According to the medical	

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		clinic report, Individual #107 sustained multiple contusions of his right foot. In addition, the report noted that the web spaces between the toes of Individual #107's feet were "moist, caked with materials, and [had] offensive odor." There was no evidence of assessment by Individual #107's nurses of his injuries or his status post-fall. In addition, there was no evidence that Individual #107's nurses responded to the incidental findings in the report and/or addressed Individual #107's poor foot hygiene. • On 9/22/10, Individual #107 was seen in the medical clinic for an evaluation of a lesion on his left ear lobe. A culture was obtained and application of antibiotic ointment four times a day was prescribed. There was no evidence that Individual #107's nurses performed assessments and conducted evaluations of his response to treatment until over two days later when his culture results came back positive for a methicillin resistant staphylococcus aureus (MRSA) infection.	
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.	According to this provision item of the Settlement Agreement, nurses are responsible to perform and document assessments that evaluate the individual's health status sufficient to identify all of the individual's health care problems, needs, and risks. • Quarterly and annual nursing assessments existed in each of the 20 sample individuals' records. • However, 16 of the 20 nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatment, to achieve desired health outcomes. Thus, a rating of noncompliance has been given to this provision item. Nursing assessment is the first step of the nursing process that one would expect to find in a facility such as EPSSLC. 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. It is from the nurses' assessment that actual problems, high-risk potential problems, and nursing diagnoses are identified, and from which plans are developed to address and/or resolve problems. Moreover, the assessment records and summarizes pertinent health data against which change can be measured and goal achievement determined. Properly completed, the standardized nursing assessment forms in use at EPSSLC referenced the collection, recording, and analysis of a comprehensive set of health	Noncompliance

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		information that led to the identification of all actual and potential health problems, and to the formulation of nursing diagnoses for the individual. For example: • For example, Individual #81 was a 21-year-old man who was diagnosed with dysthymic disorder, impulse control disorder, psychotic disorder, severe mental retardation, seizure disorder, osteoporosis, acne vulgaris, psychogenic vomiting, and insomnia. In addition, he had many behavior challenges, which included frequent episodes of self-injurious behavior. As a result, Individual #81 suffered numerous self-inflicted injuries, such as wounds to the head, eyes, tongue, hands, fingers, etc. Individual #81's RN case manager completed timely nursing assessments that provided a comprehensive review of his health status indicators, evaluated the effectiveness of his treatment with psychotropic, gastrointestinal, and sleep medications, and generated nursing diagnoses that provided an adequate basis for selection of interventions to achieve his desired health outcomes. • Individual 113's RN case manager was very knowledgeable of his current health needs and risks. In addition, she conducted research and obtained information to share with Individual #113's interdisciplinary team to help inform their interventions and plans to address one of his most challenging problems – his recurrent episodes of vomiting. Notwithstanding these positive findings, the majority of the sample individuals did not have accurate, complete, comprehensive assessments that resulted in complete lists of nursing diagnoses such that care plans/interventions could be properly developed and/or updated. There were also many other individuals who suffered significant changes in their health status between quarterly assessment periods (e.g., hospitalizations, serious illnesses, and injuries affecting health status, functioning, and overall health and well-being) whose assessments were not updated in accordance with the provisions of the Settlement Agreement and Health Care Guidelines. Thus, the conclusions (i.e., nursing diagnoses) drawn from their 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 and the selection of interventions to achieve outcomes were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Examples of these findings are presented below. • Individual #126 was a 32-year-old woman diagnosed with autism, severe mental retardation, acne vulgaris, obesity, constipation, osteopenia, hyperammonemia, hyponatremia, and poor oral hygiene. One of the interventions to address her hyponatremia was fluid restriction. Individual 126's nursing assessments failed to evaluate her compliance with this restriction and/or its effectiveness on	

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		improving her fluid/electrolyte imbalance. Individual #126's nursing assessments also failed to evaluate the effectiveness of her medications and treatments. Rather, the assessments noted the effectiveness of Individual #126's medications and treatments were either "Effective" or "Probably effective," which, absent any context, was uninformative. In addition, Individual #126's 12/21/10 nursing assessment, which reported that Individual #126 sustained a 12.5% weight loss <u>in one month</u> (emphasis added) suffered episodes of impaired skin integrity, hyponatremia, and hyperammonemia, and several significant changes in her psychotropic medication regimen to address deterioration in psychosocial functioning inaccurately portrayed Individual #126's health status and concluded with the statement that she was "…in good physical health. • Individual #195 was a 26-year-old woman who was diagnosed with profound mental retardation, diplegia and spasticity of her upper extremities, hip dysplasia, contracture of her lower extremities, seizure disorder, constipation, menorrhagia, anemia, osteopenia, vitamin D deficiency, leucopenia, neutropenia, GERD, erosive gastritis, and peripheral vascular disease. On 12/20/10, Individual #195 was seen in the medical clinic for follow-up to a report of cold lower extremities. According to Individual #195's nurse practitioner's report, upon examination, Individual #195's feet were cold to touch and had dependent rubor, and her pedal pulses were difficult to palpate. At this time Individual #195's nurse practitioner reported that he/she suspected possible venous insufficiency and ordered arterial and venous Doppler studies of Individual #195's lower extremities. Despite the seriousness and significance of this change in Individual #195's health status, there was no evidence that her nurses conducted assessments or monitoring of her circulatory status until two weeks later (1/3/11) when her nurse noted that she had "pedal edema, R pitting 2+, L pitting 1+" and he/she "talked to DCS to encourage putting both [her] legs up when in wheelchair." Notably, on 1/4/11, Individual #195 was transferred to the emergency room with an occluded distal femoral artery and occluded proximal popliteal artery. • Individual #107's most current quarterly nursing assessment was conducted on 8/30/10. Since that time, Individual #107 attended multiple medical appointments/consultations; developed cellulitis and MRSA infection of his left earlobe, had surgery (left tympanomastoidectomy), suffered significant post-operative pain, was restrained with bilateral hand mittens 24 hours a day, seven days a week throughout his post-operative period, acquired a MRSA infection of his oropharynx, spent days in isolation, and developed denudation of the skin on his buttocks and sacrum. Notwithstanding these significant changes in Individual #107's health status, needs, and risks, his nurses failed to conduct a head-to-toe, comprehensive nursing assessment in follow-up to these significant changes.	

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		• Despite Individual #4's well documented quadriplegia, contractures, severe spasticity, and high risk of impaired skin integrity, his nursing assessments inaccurately indicated "no abnormal findings" of his upper and lower extremities and significantly underestimated his Braden scale and scored him with an only "moderate" pressure ulcer risk. In addition, Individual #4's nursing assessment failed to provide an evaluation of the effectiveness of his medications and treatments. Rather, Individual #4's nurses documented the effectiveness of his medications as "Effective." • Individual #92 was diagnosed with cerebral palsy, quadriplega, and severe spasticity. During the period of Individual #92's 12/29/10 quarterly nursing assessment, she developed redness and rash in her peri-area, inguinal area, and on her inner thighs. Her nurse practitioner prescribed twice daily applications of Calmoseptine and "no tight diapers." Although Individual #92's 12/29/10 nursing assessment listed "Calmoseptine" as one of her prescribed medications, it erroneously indicated that she had "no" skin breakdown. Also, Individual #92's nursing assessment failed to reference her history of chronic pelvic inflammatory disease and/or its relevance to her diagnosis and management of dysmenorrhea. • Individual #75 was a 42-year-old man who was diagnosed with psychotic disorder, profound mental retardation, osteoporosis, acne, GERD, hiatal hernia, non-erosive gastritis, and benign scrotal mass. Individual #75's 10/22/10 nursing assessment failed to reference his history of gynecomastia, nodule on his right breast, and surgical consultation for evaluation and possible excision. Also, during the month of December 2010, Individual #75 fell and suffered serious injuries - a head injury, bruise and contusion to the left lower chest wall, and a fractured rib and clavicle. The injuries, which increased Individual #75's actual and potential risk of neurological, respiratory, behavior, and other complications failed to trigger her nurses' conduct of a head-to-toe, comprehensive nursing assessment. • Individual #195's nursing assessments failed to put forward an evaluation of the effectiveness of her medications and treatments, and it failed to adequately assess the nature and severity of her edema. In addition, the "Nursing Summary" at the end of Individual #195's 10/29/10 nursing assessment misrepresented the nature, significance, and severity of Individual #195's "only health issue requiring medical treatment," which was an "event of itching." Individual #195's nursing assessment failed to reveal that her "event of itching" was because she suffered 16 mosquito bites scattered across her arms, wrist, and foot. Individual #195's physician ordered Benadryl 25 mg four times a day for three days for the itch and implored her caregivers to "…avoid mosquito bites. Will ask QMRP to check and staff as needed on above issue."	

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		• Individual #78 was a 32-year-old woman who was diagnosed with multiple problems that increased her risk of pain – self-abuse/self-mutilation, erosive gastritis, dysmenorrhea, and migraine headaches. Despite the presence of these problems, Individual #78's nursing assessments did not evaluate her actual/potential risk of pain or include an analysis of her methods of, as well as barriers to, communication of pain. Individual #78's nursing assessment noted that she was "not verbal and pain is determined based on SIB or gestures," but it did not provide explanation or elaboration of whether or not SIB occurred in anticipation of and/or in response to pain, the frequently observed types of behavior(s) that occurred proximate to identification of pain, the types of gesture(s) used to indicate pain, and whether or not she had preferred staff members (for purposes of communication). • Individual #78's 11/19/10 nursing assessments noted that she "vomited six times this quarter," but failed to explain the nature, severity, and significance of this finding and/or other relevant, pertinent information, such as what, if any, untoward events occurred as a result of the episodes of vomiting, whether or not the episodes occurred before or after meals, how the episodes were addressed. • Individual #32's nursing assessments failed to reference an evaluation of the effectiveness of his medications and treatments, his hearing impairment, his oral hygiene, and the nature and severity of his allergic rhinitis. • Under the section, "Cardiovascular" status, Individual #71's nursing assessments failed to reference his hypertension; under the section, "Respiratory," nursing assessments failed to reference to his history of pneumonia; under the section, "EENT," nursing assessments failed to reference his vision impairment; and the section, "Immunizations" was blank. Also, Individual #71's 11/10 nursing assessment's section, "End of Life Planning" failed to indicate that his family had requested a change in his DNR status. Rather, this section was left blank. Some general comments are listed below: • None of the 20 sample individuals' nursing assessments referenced complete information pertaining to individuals' immunization histories. The items most often left blank were histories of MMRs, Hepatitis A and/or B, varicella, and zoster immunization. • Eight of the 20 sample individuals' nursing assessments failed to indicate that their nurses conducted monitoring of their meal time and/or the results of their monitoring. • The dental reports of 11 of the 20 sample individuals indicated that they required "general anesthesia for dental care." Although this procedure poses significant actual and potential health risks to the individuals, this aspect of their health care was not evaluated in their nursing assessments.	

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		• In general, the nursing assessments did not include an informative evaluation of the individuals' response to and/or effectiveness of their medications and treatments. Rather, the evaluations of the effectiveness of the medications and treatments were limited to one or two words - "Effective," "Not effective," "Probably effective," or the evaluations were blank. • Only one of the 20 sample individuals' nursing assessments resulted in a complete list of nursing diagnoses that accurately reflected the nurses' clinical judgments. • A significant minority of the nursing assessments indicated that nonverbal individuals' pain might be determined by their self-injurious behavior, and gestures, however, none of these assessments referenced an evaluation of the location, intensity, onset, duration, quality, etc. of the individuals' pain, and none explained how, where, when, and what behaviors/gestures were associated with the individuals' communication of pain. • Individuals' persistent, recurring problems, such as alteration in skin integrity, infection, vomiting, diarrhea, insomnia, etc., were usually noted by their nurses in the nursing assessments, but they were not adequately evaluated, diagnosed, or addressed vis a vis care plan(s).	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Health management plans (HMPs) and acute care plans (ACPs) existed at EPSSLC. During the Fall of 2010, the nursing staff members at EPSSLC reported that they received the new health management plan, process, and form/format, which was prepared and distributed by the state, but had not developed the "new plans" for the majority of the individuals. According to the EPSSLC CNE, the HMPs and ACPs needed improvement, especially with respect to the review/revision of plans in response to clinical indicators. In an effort to improve performance in this area and achieve compliance with this provision item, the facility's nurses were provided re-education and training on the individualization of care plans, proper care plan development for high risk individuals, and process of collaboration with the interdisciplinary team vis a vis the PSP process to inform the development of the HMPs and ACPs. In addition, a "Care Plan Library" was established on the shared drive of the facility's electronic record-keeping system, and it made stock care plans available and accessible to all nurses across the campus. In a facility, such as EPSSLC, health management plans and acute care plans 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. In total, the nursing care plans should reference all of the individual's acute health issues, including injuries, actual and potential health risks, restorative and habilitative needs, and	Noncompliance

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		chronic/long term health needs. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of the interventions. 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 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. Part of the problems noted in the HMPs and ACPs were due to the problems noted above in nurses' response to individuals emergent health needs and risk and nursing assessments and diagnoses (see above sections M1 and M2 of this report). The rest of the problems noted in the HMPs and ACPs were largely due to the persistent pattern of failure to: 1. incorporate all relevant data from systems' assessments into the HMPs and ACPs, 2. reference all health risks and actual problems in the HMPs and ACPs, and 3. update HMPs and ACPs as needed to ensure they addressed all current health needs at all times. Some general comments are presented below. • Across the 20 sample individuals reviewed, HMPs and ACPs varied in form/format. Some of the HMPs and ACPs were of the current, preferred, and state-approved form/format, but most were not. • Across the 20 sample individuals reviewed, HMPs and ACPs were not consistently dated with the date(s) of implementation and/or resolution. • In 19 of the 20 sample individuals reviewed (95%), the HMPs did not consistently address all of the health care needs of the individuals; and ACPs were not consistently prepared in a timely manner, or at all, in response to individuals' acute and/ or emergent health care needs and risks. • Five of the 20 sample individuals had recommendations by their physician/nurse practitioner for development and implementation of exercise programs. As of the monitoring review, none had been developed. • Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, the HMPs and ACPs were not revised, and they did not reflect the most current conditions and intervention strategies. • There was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and current ACPs to ensure that	

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		the plans continued to be appropriate and relevant to the individuals' health status, and if they did not, the plans were changed. • 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 the formulation of their desired health outcomes. • To date, the 20 sample individuals had not participated in the new PSP process. Thus, similar to the findings in the prior review, the "Nursing Assessment" portion of 18 of the 20 individuals' PSPs was not informative and did not provide even an adequate 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. In several instances, no nursing input was provided during the formulation of the PSP. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #73 was a 23-year-old woman who was diagnosed with schizophrenia, depression, moderate mental retardation, and a host of medical problems, including seizure disorder, hypothyroidism, constipation, and osteopenia. Over the past several months, her psychiatrist repeatedly noted that she was "Doing rather poorly," "Behavior worsening," "Quite unstable," and "Difficult to manage." Although Individual #73 had an HMP developed to address the side effects of her multiple psychotropic medication regimen, she did not have an HMP in place to address her psychosocial needs and the behavioral manifestations of her distress (pacing, crying, hitting herself, and aggressive behavior toward others). • Despite Individual #73's unremitting problems with constipation, vomiting, overeating, and not eating, many of the HMPs developed to address her gastrointestinal problems had not been revised. • In addition, on 12/23/10, Individual #73 was diagnosed with diverticulitis and prescribed antibiotics; and on 12/24/10, Individual #73 was hospitalized with acute renal failure and lithium toxicity. As of the monitoring review (1/5/11), Individual #73 did not have ACPs developed to address these acute health problems. • Individual #51 was a 45-year-old African-American man at risk for heart disease, diabetes, and stroke. In September 2010, Individual #51's physician noted that he was at high risk for heart disease because of his diagnoses of hyperlipidemia, hypertriglyceridemia, and obesity, and his concurrent use of fluoxetine and propranolol, which may result in increased risk of heart block. In December 2010, Individual #51's physician reaffirmed his concern that Individual #51 was at "high risk for [cardio]myopathy." Although Individual #51 had an HMP developed to address his elevated cholesterol, it had not been	

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		expanded to include and/or address his high risk for cardiac problems, disease, and/or complications. • On 12/1/10, Individual #51 was congested and coughing. On 12/2/10, his physician diagnosed him with an upper respiratory infection. There was no ACP developed to address Individual #51's acute health problem. • Individual #93 was a medically fragile 54-year-old woman. Over the past year, she suffered frequent injuries and weight loss. On 10/11/10, Individual #93 was hospitalized for treatment of tachycardia, cough, and fever. She was diagnosed with urosepsis and treated with antibiotics and monitored by telemetry. Individual #93 had five HMPs: GERD, osteoporosis, skin integrity, weight, and constipation/impaction - that were originally developed in 2008 and "continued" in 2009. She also had one HMP – gastrostomy/enteral tube – that was originally developed on 10/20/10. Despite the significant changes in Individual #93's health over the past year, there was no evidence that any of her plans " had been reviewed/revised. Also, there was no evidence that her plans had been reviewed and continued to be relevant and appropriate for implementation during 2010-2011. In addition, there was no HMP in place to address Individual #93's additional health risk: her diagnosis of tachycardia. • For many months, Individual #38's clinical professionals had been stymied by his self-injurious behavior and aggressive episodes that continued unabated despite his receipt of numerous psychotropic medications and frequent medical consultations. During the past five months, on an almost daily basis Individual #38 had been observed grimacing, crying, and hitting himself about the head and ears to the point of creating head contusions. His physician, ENT, and dentist evaluated him on several occasions to rule-out a medical reason for his apparent "pain." He was prescribed migraine prophylaxis, antibiotics, pain medication, and psychotropic drugs, but nothing helped. As of the monitoring review, there were no plans in place (either HMP or ACP) to address Individual #38's significant pain management issues or his periapical abscess. Of note, on 9/22/10, Individual #38's dentist reported that he/she found a "periapical abscess" of Individual #38's tooth #9. At this time, the dentist indicated that he/she would refer Individual #38 to the endodontist. There was no evidence of follow-up. On 11/1/10, Individual #38's dentist again reported that he found a "periapical abscess with fistula" of Individual #38's tooth #9. Again, there was no evidence of follow-up. According to the American Dental Association, a periapical abscess is associated with constant, throbbing severe pain. Also, when there is a periapical abscess with fistula, a severe pain reaction is experienced. Finally, the ADA indicated that an emergency treatment plan should be developed and implemented for persons with periapical abscess. If there has continued to be no follow-up to the dentist's reports, it is strongly	

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		recommended that Individual #38's nurse case manager ensure that his physician is aware of the dentist's reports and his 9/22/10 recommendation. • Individual #71 was a 57-year-old African-American man with many chronic health problems and needs. He was diagnosed with contractures, GERD, osteoporosis, seizure disorder, constipation, hypertension, benign prostatic hypertrophy, blindness right eye, incontinence, and gingivitis. In December 2010, Individual #71 lost 10 pounds in one month and developed hyponatremia. Thus, his physician ordered an adjustment to his total water intake via enteral tube. At the time of the monitoring review, the only care plan filed in Individual #71's record was a single HMP, which was developed on 2/13/09, to address Individual #71's change in intake from oral to enteral nutrition. • Individual #108 was a 29-year-old woman who was diagnosed with depression, panic/anxiety disorder, profound mental retardation, cerebral palsy, hemiplegia, seizure disorder, constipation, gingivitis, mild hearing loss, dysmenorrhea, and insomnia. According to her psychiatrist, she had a "profound problem with her sleeping habits" and she needed to be referred to the psychiatric clinic due to her dysmenorrhea and its relation to her psychotropic medication regimen. There was no evidence that Individual #108's 12/12/08 HMP related to "sleep disturbance" had been reviewed/revised for over two years. Notably, it continued to reference sleep medications that were no longer currently prescribed for her. In addition, Individual #108 did not have an HMP to address her dysmenorrhea. Thus, it was not surprising that there was no evidence of follow-up to her clinical professional's 5/21/10 recommendation for a pelvic examination and PAP test. • Individual #108 had a 2008 HMP to address "weight management." According to this 2008 plan, Individual #108's goal was to lose one to two pounds a month until she achieved her desired weight range. However, during 2008-2009, Individual #108 gained weight, but her plan was not revised. During the Spring of 2010, Individual #108 lost weight and her PST convened a "special review" to address her weight loss, but her plan was still not revised. During the Fall-Winter of 2010, Individual #108 again gained a considerable amount of weight and weighed more than when her weight management plan was initially developed, but Individual #108's 2008 weight management plan was not revised. Despite the fact that the plan had an undesirable "yo-yo [diet]" effect, as of the monitoring review, it remained in place. • Individual #60 was a 56-year-old woman who was diagnosed with osteoporosis, obesity, and lymphedema. According to her RN case manager, she had "declined in steadiness," "uses wheelchair more and more," and "continues to fall every so often (sic)." As of the monitoring review, Individual #60 failed to have HMPs to address her decline in mobility and "high risk of injury due to falls" (from	

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		9/24/10 Comprehensive Nursing Assessment). • Individual #33 was a 50-year-old woman who was diagnosed with multiple medical problems – dysphagia, erosive gastritis and duodenitis, GERD, hiatal hernia, constipation, hyperlipidemia, osteopenia, seizure disorder, gingivitis, onychomycosis, and inclusion cyst left axilla. Notwithstanding all of her identified chronic health problems and needs, at the time of the monitoring review, she had only three 2008 HMPs – constipation, seizure disorder, and GERD. Most of Individual #33's chronic health conditions were not addressed with HMPs. Also, there was no evidence that any one of the three 2008 HMPs had been reviewed after July 2009. In addition, there was no ACP developed to address and monitor Individual #33's recent, diagnosed inclusion cyst of her left axilla. • Individual #113's RN case manager summed it up best when he/she wrote, "Individual #113 has had a rough quarter (from 10/31/10 Comprehensive Nursing Assessment)." Of note, during the monitoring team's interview with Individual #113's RN case manager, it was clear that she was involved in his assessment, planning, and delivery of health care services and knowledgeable of his multiple health needs and risks, including some of his recent and protracted problems, which included infection, uncontrolled diabetes, pain, vomiting, etc. Notwithstanding this positive finding, as of the monitoring review, there were no HMPs and/or ACPs in place to address Individual #113's GERD, high risk of choking and aspiration, nausea, vomiting, pancreatitis, and pain. Curiously, Individual #113 had a "Nausea/Vomiting and Diarrhea" HMP filed in his record, but it only referenced diarrhea, and was not developed to address his nausea/vomiting or individualized to meet Individual #113's challenging and complex health needs. • Individual #126 was a 32-year-old woman diagnosed with autism, severe mental retardation, seizure disorder, obesity, constipation, osteopenia, gingivitis, hyponatremia, and hyperammonemia. During the period of 9/21/10-12/21/10, Individual #126 lost 12.5% of her body weight in one-month and developed granuloma annulare, a chronic degenerative skin disorder, hyponatremia, and hyperammonemia, and experienced several significant changes in her psychotropic medications. Individual #126's physician prescribed fluid restriction to address her hyponatremia. Also during this three-month period, Individual #126 continued to leave her day program, and she was often observed sitting outside on the ground during her workshop period and groups. Despite these significant changes in Individual #126's health status, her 5/27/10 HMPs related to hyponatremia and weight management were not revised. Although Individual #126's RN case manager noted that Individual #126 lost almost 20 pounds in one month, he/she did failed to address the significant	

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		precipitous weight loss, but noted, "She remains one pound over her IBW and her abdomen appears distended." There was no evidence that Individual #126's RN case manager requested re-weighing her, obtained information regarding her intake/appetite at mealtime, assessed her abdominal girth, evaluated her for complications of hyponatremia/hyperammonemia, or took any other action that a reasonable nurse would do in a similar situation. • Also, there was no HMP developed to address Individual #126's impaired skin integrity, and Individual #126's HMP related to her constipation/impaction was not individualized to meet her particular needs. For example, Individual #126's HMP continued to recommend staff "to encourage fluids but only in harmony with fluid restrictions, if any," and failed to specify that, indeed, she had fluid restriction and would benefit from various other interventions to promote her bowel regularity.	
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, since the prior review, some assessment and reporting protocols had changed and, due to the vacancies in nursing leadership positions, other assessments and reporting protocols were shared by various nursing leadership and direct care nursing staff members. For example, since the prior monitoring review, the RN case managers were no longer responsible for the quarterly assessment of meals and reporting of outcomes of their meal monitoring activities. These assessments and reports were reassigned to the "floor nurses." As noted in section M2, monitoring meals and reporting the results of the monitoring had declined since the prior review. The RN case managers, however, were assigned the duties of obtaining informed consent for psychotropic medications, completion of medication justification forms, and ordering therapeutic mattresses. In regard to vacancies, although the raw number of vacant nursing positions reported by the facility decreased from 13.5 in July 2010 to 3.4 in January 2011, the number of vacant nursing leadership positions increased from 0 in July 2010 to 3.0 in January 2011. This occurred as a result of a shift in vacant positions from direct care nursing positions to nursing leadership positions. Thus, as of the current monitoring review, the positions of Nurse Liaison, Nurse Educator, Campus Nurse Supervisor, and Nurse Manager positions were vacant. These vacancies had a significant negative effect on the facility's ability to make progress toward compliance with provisions in sections M1 – M6 of the Settlement Agreement. As noted above, numerous problems, described above in sections M1, M2, and M3, were identified in the areas of nursing assessment and reporting. Thus, the anticipated positive outcomes for individuals due to the implementation of these protocols were not yet evident in the 20 records reviewed. As of the current monitoring review, although the CNE was hopeful that good candidates would come along, there were no plans to actively recruit a Nurse Educator/Nurse Liaison.	Noncompliance

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		At EPSSLC, the Chief Nurse Executive, Nursing Operations Officer, Infection Control Nurse, Quality Enhancement Nurse, Campus Nurse Supervisor, Nurse Manager, Nurse Case Managers, and direct care nurses all had a role and responsibility to ensure the implementation of nursing assessment and reporting protocols to address the health status of the individuals. The facility's Department of Nursing met on a monthly basis. During these meetings, the nursing management team presented new and revised policies and procedures, reviewed the role and responsibilities of nurses across various processes and protocols (e.g., "Learning to Write Case Notes Using SOAP Format"), discussed the results of various monitoring tools (Assessment, Care Plans, Acute Illness/Injury, Seizure Management, Medication Administration), and made recommendations to improve the delivery of nursing supports and services across the facility. Over the past six months, the Chief Nurse Executive and Nursing Operations Officer described several initiatives they have implemented to help communicate their expectations for the delivery of quality nursing care to the facility nurses. In addition, they have covered some of the duties of the Nurse Educator and Nurse Liaison. For example, they ensured that re-education and training was provided to the facility's nurses to improve their performance in some circumscribed areas (e.g., documentation of IPNs using SOAP format, 24-hour shift report, individualization of care plans, medication administration practices). According to the NOO, over the past six months, the focus of their efforts has been on enforcing expectations for nurses to comply with basic standards of nursing practice. The CNE and NOO also reported that they had spent considerable time and effort working with other disciplines to create and shape systems of communication and collaboration between departments and among members of the interdisciplinary team to improve the assessment of health risk and identification of health risks vis a vis HMPs and ACPs. Thus, the CNE and NOO were certain that progress had been made in improving nurses' documentation of assessments. Other members of nursing leadership echoed these reports and offered similar opinions, such as that attitudes were more positive, staffing levels and coverage had improved, interdisciplinary collaboration was occurring, and the nursing management group had come together as a team. Nonetheless, the CNE and NOO were acutely aware of the frustrations of the nursing supervisors and nurse case managers. These nurses frequently reported that they were overwhelmed with multiple meetings that consumed hours of their days and days of their weeks and took them away from their duties to perform assessments, develop HMPs and ACPs, and ensure that all of the individuals' health care needs were being met. The NOO indicated that it was her opinion that assigning one case manager per	

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		residential area would help improve the case managers' ability to meet the deadlines for assessments and time frames for reporting. The CNE reaffirmed that she was 100% committed to meeting the provisions of the Settlement Agreement. Some of the obstacles that continued to stand in the way of progress toward compliance were • assignment of administrative assistant/data entry tasks to nursing management, • lack of a well-qualified, experienced Nurse Educator who could hit the job running, and • inadequate systems in place to help support the nurses attain successful reduction of medication errors and sustain improvement in the quality and accountability of medication administration practices. As noted above, the Nurse Educator and Hospital Liaison positions were vacant. Their absence had created a significant absence of education and training in health and nursing care and in ensuring that individuals who were hospitalized were appropriately monitored. For example, no one in the Nursing Department ensured that three direct care staff members who "failed," "had horrible sessions," and "needed tons of coaching" during a mock medical emergency drills held several months ago received re-training through the CTD and/or ensured that the provision of re-training and education in CPR to ensure that they could safely and appropriately respond to individuals' emergency situations. Also, when the monitoring team asked to review the training and education materials, curriculum, agendas, and attendance sheets for the Nursing Department, a large binder containing old and new handouts, information sheets, copies of outdated policies, and e-mail messages from years ago exchanged among nursing staff members about particular individuals, and sign-in sheets, some of which referenced the signatures of nurses who "signed in" as having attended the training three years ago along with signatures of nurses who "signed in" several months ago, was provided. In addition, it was reported that there were no data maintained by the facility that tracked and recorded training and education received by individual nurses. Thus, the only way to determine the training and education received by a particular nurse, required paging through hundreds of sign-in sheets. According to the CNE, the Nurse Recruiter was helping to cover this aspect of service delivery, but during the monitoring team's interview with the Nurse Recruiter, it was clear that she had not had time, training, education, or experience to competently assume these duties. As noted above, nurse managers and supervisors were reportedly covering the duties of	

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		the Hospital Liaison. The nurse managers and supervisors were quick to point out that they did not visit individuals in the hospital. Rather, the requirement was for them to receive a daily verbal report from the hospital nurse regarding the individual's status and response to treatment. However, a review of the hospitalized sample individuals' records failed to corroborate this report. There was no evidence that daily contact was consistently made and no evidence that appropriate monitoring of the individuals' status and response to treatment while hospitalized had occurred. Over the past six months, one area of assessment and reporting protocols that showed significant improvement was the area of Infection Control. Since the prior monitoring visit, the Infection Control (IC) Nurse prepared a presentation book, which showcased the accomplishments of the Infection Control Department. The IC Nurse conducted quarterly Infection Control Committee meetings. At these meetings, he presented surveillance data of the frequency of various types of infections that occurred across the facility during the prior quarter. He also pointed out problematic patterns and trends, discussion ensued, recommendations were put forward, and, once approved, he ensured follow-up to the approved recommendations. The IC Nurse attended direct care staff members' and nurses' shift reports, reviewed physician's orders, visited individuals diagnosed with infections, and prepared Corrective Action Plans in response to occurrences of infections, wound, skin, ear, MRSA, etc. When infections required the notification of external agencies/officials, they were reported in a timely manner, and their recommendations were implemented. The IC Nurse evaluated the individuals' responses to treatment until their infections were resolved. The IC Nurse also conducted monitoring, assessment, and reporting of employee infections. Through these efforts, the IC Nurse has been instrumental in fostering at least one employee's adherence to medical specialist's recommendations for treatment and monitoring of his/her recent hepatitis infection. During an interview with the Quality Assurance (QA) Nurse, over the past six months, she had: • conducted monitoring and evaluation of assessment and reporting protocols, • established the reliability of her findings/outcomes of her reviews with those of the nurse case managers, and • submitted her data/findings to the facility's QA data analyst for analysis and reporting. Also see comments in section E of this report. One startling revelation during the monitoring team's interview with the QA Nurse was	

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		her report, which was confirmed during a QA Department meeting, that neither the Nursing nor Dental Departments wanted to receive the findings from the QA Nurse's monitoring of nursing and dental care. This was unfortunate and not consistent with the reports from nursing leadership regarding their desire for collaboration, communication, and coordination of improvement efforts. As noted in the prior monitoring report, the QA Nurse is not a member of the nursing department. Over the past six months, there appeared to be fewer attempts by the nursing department to avail themselves of her knowledge and expertise. The QA Nurse's monitoring reports, which included, but were not limited to "Death Reviews," were comprehensive, complete, thoughtful, appropriately critical, and well documented. They highlighted the persistent pattern of problems in nursing assessments, documentation, reporting, and planning processes. However, as of the monitoring review, the Nursing Department failed to respond to any of the recommendations put forward in these reports, which was, again, not consistent with their reported desire to improve the quality of nursing care, while ensuring individuals' health and safety. At the time of this review, the Nurse Recruiter reported that there were only 3.4 vacancies in the nursing department, which was an 82% reduction in vacancies since the prior monitoring review. According to the Nurse Recruiter, LVNs continued to be readily available for hire, but it remained more difficult to recruit RNs. Since the prior review, the facility has continued to use agency nurses and overtime to address unscheduled absence. Also since the prior review, the nurses received more reimbursement for on-call duties, which was well received. The Nurse Recruiter reported that she has noted "more positive attitudes" among nursing staff members and less job dissatisfaction. These were anecdotal impressions and not based on the recent Job Satisfaction Survey, which resulted in only one respondent. Notably, the Nurse Recruiter was not involved with planning recruitment strategies and/or actively seeking qualified, experienced nurses to fill the Nurse Supervisor, Nurse Educator, and Nurse Liaison vacancies.	
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	At the time of the monitoring review, EPSSLC had just begun its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. EPSSLC implemented the Health Risk Assessment Rating Tool as part of their efforts to consistently assess and identify each individual's level 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. Additional rating tools were completed for risks associated with dental	Noncompliance

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	plans and progress at integrated reviews as indicated by the health status of the individual.	status. During the conduct of this review, the monitoring team attended a quarterly PST meeting that included an evaluation of the individual's risk, in accordance with the state's approved rating tool and assessment process. The individual's mother attended the meeting, as did all members of the individual's interdisciplinary team. The QMRP who chaired the meeting effectively ensured translation of English to Spanish so that information would be communicated to the Spanish-speaking individual and her mother in a real-time manner. The QMRP did a fair job keeping the meeting focused on the assessment of risk, but did relinquish some of that role/responsibility to the individual's physician, which seemed to help keep the discussion focused on risk assessment, and it did not take away from the process. The RN case manager's conduct during the meeting needed improvement. She came to the meeting somewhat prepared, but frequently did not have a well-informed and/or well-formulated opinion regarding the individual's level of risk for particular areas of health status. In addition, the case manager was frequently inconsiderate of and disrespectful toward the individual and her mother. For example, when the case manager was asked about the individual's "family history" of particular diseases, the case manager bluntly stated, "I don't know the family's history." It would have been better had the case manager included the individual and her mother in the discussion and/or ask them if they could help the PST know and understand the individual's family's health history. Also, when the case manager was asked whether or not the individual suffered from heartburn, she replied, "I don't know, she's nonverbal." Again, this response was not duly considerate and respectful of the individual. It was clear during the conduct of the meeting that the individual had abilities to communicate many of her thoughts, feelings, and wishes. It was also clear that there were observable signs/symptoms of heartburn that were the case manager's duty and responsibility to know and describe to the PST. According to Valerie Kipfer, State Office Nursing Services Coordinator, who presented an informative review of the status of the state's risk assessment process, all individuals will be captured by the new system of risk assessment by 4/1/11. This was reassuring since the majority of the 20 sample individuals' assignments of their level of risk had not been reviewed since August 2010-September, 2010, and many had not received a review of their risk across all of the identified areas of risk. All of the 20 sample individuals had multiple risks related to their health and/or behavior, and many had one or more "high" health risks. As noted in the previous reviews, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated	

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		as being in noncompliance. Of note, reviewing and revising the individual's health risk rating upon significant change in condition was not a new expectation, it had always been a requirement. Examples included the following: • Over the past several months, Individual #92 had suffered two episodes of aspiration pneumonia. In addition, on 11/15/10, her nurse noted, "Individual #92 sneezed while getting her last 60 cc of formula g.t. bolus. Client then had emesis immediately (< 1 second), approximately 200 cc formula." Again, on 11/27/10, 12/13/10, and 12/17/10, Individual #92 vomited after her enteral feeding. Despite these significant events, Individual #92's risk assessment had not been revised, and she was not rated at high risk for choking or aspiration. • Individual #92 was incontinent and also suffered recurrent problems with skin rash and erythema in her peri-area, thighs, and buttocks. In addition, on 11/19/10, Individual #92's nurse noted, "[She] continues to have bad body odor…" There was no follow-up to these problems, and Individual #92 remained at "medium" risk related to alteration in skin integrity. • Despite Individual #188's PPD conversion from non-reactivity to reactivity and prescribed treatment with INH, her risk assessment was not revised, and she remained at low medical and respiratory risk. • Over the past several months, Individual #71 lost 10 pounds in one month, developed hyponatremia, was hospitalized due to rectal bleeding, and suffered a urinary tract infection. Despite these significant changes in Individual #71's health status, Individual #71's health risks were not reviewed/revised. • In September 2010 and again in November 2010, Individual #38's dentist noted that Individual #38 had a periapical abscess of this tooth. There was no follow-up to Individual #38's dentist's recommendation for him to see an endodontist. According to the American Dental Association, a periapical abscess is associated with constant, throbbing severe pain. Also, when there is a periapical abscess with fistula, a severe pain reaction is experienced. Finally, the ADA indicated that an emergency treatment plan should be developed and implemented for persons with periapical abscess. Individual #38's health risk related to his dental/oral hygiene had not been reviewed/revised in light of this serious problem.	
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	The administration of medication and the management of the medication administration system at EPSSLC had improved since the previous monitoring review. As indicated in more detail below, although much work still needed to be done to ensure that medications were administered and accounted for in accordance with standards of practice and the Health Care Guidelines, the facility had taken several steps toward	Noncompliance

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	administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	identifying and measuring the nature, severity and scope of their problems in this area. This provision item, however, was rated as being in noncompliance because there continued to be serious problems in this area. The facility's Medication Error Committee identified many of these problems. During the review, medication administration observations were conducted on Dorms A, B, and C, 508, 509, 510, and 513. As noted in previous reviews, observation of medication passes revealed numerous problems with nurses' compliance with standards of practice and the Health Care Guidelines. • Nurses did not consistently wash and/or sanitize their hands prior to pouring medications and/or between contacts with individuals. • Nurses were observed setting up and, sometimes, documenting the individuals' receipt of medications on the Medication Administration Records (MARs) prior to administration. • For all individuals across all residential areas, nurses used tongue depressors, rather than spoons, to administer oral medications. There was no medical/clinical rationale/justification for this method, and it created the potential risk of harm. Thus, this observation was immediately reported to nursing leadership. The use of tongue depressors was an especially risky practice when it involved individuals with strong gag reflexes, individuals with specific utensil recommendations for medication administration (e.g., mothercare spoon), individuals who had difficulty with lip closure and ended up with most of their crushed medication mixed with pudding on their lips and chin, individuals who were uncooperative or defensive when the tongue depressors were pushed too far into their mouths, and so forth. • During nurses' checks of residual volume prior to enteral administration of medication and formula, nurses used 60 cc syringes to check for 100 cc (or greater) residual volume. The size of the syringe failed to permit a safe and acceptable method of checking for 100 cc residual volume. The facility, following the week of the onsite review, reported to the monitoring team that the standard of practice to check for gastric residual was to use a 60 cc syringe to aspirate stomach contents. If more than 60 cc residual was found, the syringe was to be capped and an additional 60 cc syringe was to be used to determine the total amount of residual. The total amount was to then be returned to the individual. o This, however, was not what was occurred at EPSSLC. Instead, only one 60 cc syringe was used. The 60 cc of aspirated stomach contents were aspirated and dispensed into a drinking cup, then additional contents	

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		were aspirated and again dispensed into the same drinking cup. The stomach contents were then drawn up from the drinking cup 60 cc at a time and put back into the stomach via enteral tube. All of the individuals reviewed had either a SAM (self-administration of medication) or a pre-SAM assessment and designation filed in their record. During the observations of medication administration, 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. Although most individuals' nurses treated them with respect during medication administration, one nurse, during one medication administration observation did not. During this observation of medication administration, the nurse failed to greet or acknowledge the individuals or give advance notice that they were about to receive medication prior to the administration of medication(s) in their mouth with tongue depressors. This had an especially untoward effect on individuals with hearing/vision impairments and/or attention deficits. For one individual, this nurse's conduct, that is, the unexpected and precipitous pouring of liquid medication into the individual's mouth while his head was tilted back and his eyes were fixed on the ceiling, ended with the individual having coughed and regurgitated his medication(s) onto his chest and clothes. This conduct was unacceptable and reported by the monitoring team to nursing leadership. According to minutes from the Medication Error Committee, there was quarterly monitoring of the nurses medication administration practice to increase oversight and address deficiencies in practice, and nurses' counting and documenting of individuals' medications. The results of the medication monitoring reviews were filed in the nurses' personnel files. According to a review of these reports, not one of the monitoring reviews has resulted in a score less than perfect/near-perfect. The review of the 20 sample individuals' December 2010 – January 2011 MARs revealed the following problems: • Individual #93's 12/8/10-12/10/10 Jevity 300 ml QID, 12/7/10-1/2/11 diaper rash ointment PRN used 7x, 12/8/10 diazepam 4 mg were not documented as given, and 12/8/10-12/18/10 weekly weights were not documented. • Individual #6's 12/7/10, 12/25/10, and 12/31/10 sucralfate 1 gm was not signed as given. • Individual #71's 12/7/10, 12/24/10, 1/1/11, and 1/2/11 stannous fluoride was no documented as given. • Individual #4's 1/1/11 baclofen 10 mg, 1/1/11 calcium with vitamin D 500/200,	

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		1/1/11 docusate sodium 100 mg, 1/1/11 lactulose solution 30 ml, 1/1/11, 1/3/11 lamotragine 200mg, 1/1/11 prevacid 30 mg, 1/1/11, 1/3/11 metoprolol 25mg, 1/1/11 multivitamin, 1/1/11 tamulosin .4 mg, 1/1/11, 1/3/11 zonisamide 200 mg, 12/27/10, 12/31/10 dulcolax suppository 10 mg, and 12/17/10, 1/1/11 clindamycin 1% ointment, were not documented as given. • Individual #92's 12/28/10 fosamax 70 mg, 12/8/10, 12/17/10 chlorhexidine+ mouthwash, 12/17/10 jevity 1 cal, 12/9/10, 12/29/10 calmoseptine ointment, and 12/16/10 fluticasone prop+ spray were not documented as given. • Individual #73's 1/4/11 lactulose 30 ml, 1/4/11-1/5/11 lamotrigine 200mg, 1/4/11 dulcolax suppository 5mg, 1/4/11 calcium with vitamin D 500/200, 1/4/11, 1/5/11 docusate sodium 100 mg, 1/4/11 levothyroxine 50 mcg, and 1/4/11 metamucil 1 scoop were not documented as given, and 12/29/10, 12/31/10 vital signs and sPO2 were not documented. • Individual #126's 1/4/11 amantadine 100 mg, 1/4/11 calcium with vitamin D 500/200, 1/4/11 docusate sodium 100 mg, 12/30/10 oxcarbazepine 300 mg, 12/23/10 clindamycin 1% solution, and 12/23/10, 12/24/10, and 1/4/11 fluocinonide .05% cream were not documented as given. • Individual #195's 12/25/10 calcium with vitamin D, 12/25/10 carbamazapine 200 mg, 12/25/10 clonazepam .25 mg, 12/25/10 docusate sodium 100 mg, 12/25/10 nephron fa, 12/25/10 folic acid 3 mg, 12/25/10 lactulose 45 ml, 12/17/10, 12/25/10 multivitamin, 12/1710, 12/25/10 omeprazole, and 12/17/10, 12/25/10 bactrim DS were not documented as given. • Individual #188's 12/14/10, 12/15/10, 12/18/10, 12/22/10, 12/24/10, 12/25/10, 12/26/10, 12/27/10, 12/28/10, and 1/4/11 daily blood pressure not documented. • Individual #116's 1/2/11 sucralfate 1 gm, 12/30/10, 1/1/11, and 1/2/11 albuterol .83/mg/ml and ipratropium bromide + solution were not documented as given. • Individual #60's 12/31/10 blood pressure and 1/1/11 weight were not documented. • Individual #102's 12/28/10 calcium with vitamin D 500/200, 12/28/10 fluvoxamine maleate 50 mg, 12/28/10 lactulose 45 ml, 12/28/10 levetiracetam 1500mg, 12/28/10 toprimate 200 mg, 12/28/10 clotrimazole 1% cream, and 12/28/10 nystatin 100,000 cream were not documented as given. The Nurse Manager maintained an extensive database on medications that were returned to the pharmacy without explanation. Medications returned to the pharmacy without explanation/reconciliation were identified and counted as medication errors. The database included the name of the medication, resident, nurse on duty, and, once identified, the reason for why the medication was not given. According to the Nurse	

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		Manager, she was at least a month behind on entering these data into her database. The reason for why she was behind was because during the month of November 2010, she attempted to ascertain why 356 medications were returned to the pharmacy without explanation. The Nurse Manager also reported that she had not analyzed these data for patterns and trends, but planned to do so in the near future. Over the past several months, The Medication Error Committee had analyzed the medication error data and identified that the downward trend in medication errors had changed to an increased trend in errors. Thus, they concluded that the initial corrective action plan that was designed to identify the nature, scope and severity of the problem had been successful. But, now the next step must be taken in order to effectively reduce errors and improve medication reconciliation. Thus, the following initiatives were put forward for consideration and approval by the Committee: • Spread the bin exchanges over a four-day versus three-day period and reduce the amount of medication exchanged on any one day, • Change the times of medication administration from multiple, varied times to four discrete times of day – morning, noon, evening, and bedtime, • Identify nurses with a patterns of error(s) to focus training, education, and performance improvement activities, • Enlist help of Residential Director in articulating expectations for direct care staff to better assist individuals (and nurses) during medication administration (e.g., assist one individual at a time to the medication area, properly identify the individual), and • Establish dedicated medication pass hour(s) to reduce nurses' distractions and conflicts with other duties. As of the monitoring review, the above-referenced initiatives were pending further review.	

Recommendations:

1. The facility should develop a plan to recruit a Nurse Educator, Nurse Liaison, and Campus Supervisor.

2. The Medication Error Committee should take steps toward significantly reducing the substantial number of medication errors that occur on a monthly basis. One step may be to enlist the help of the Quality Enhancement Department to help analyze the voluminous data that has been collected and entered into a database maintained by the Nursing Department.

3. Unless there are medical/clinical justifications/rationales, the use of tongue depressors for the administration of oral medications should be discontinued in favor of spoons and/or the utensil(s) recommended by the Habilitation Department.

4. Medication Administration Records should include up-to-date photographs and medication presentation strategies are current and clearly documented.

5. Stop the current practice of using 60 cc syringes to check the residual volume for individuals with enteral feeding tubes because the size of the syringe does not permit a safe and acceptable means of checking for amounts of residual volume greater than or equal to 100 cc, as ordered by their physician.

6. Ensure that nursing assessments are accurate, complete, comprehensive and updated when there are significant changes in the individual's health status and/or functioning.

7. Adjust the timetable of the "QMRP quarterlies" such that it overlaps with the timetable of the individuals' quarterly nursing assessments, or vice versa.

8. Identify strategies to reduce the number of "mini-staffing" meetings, which the nurse case manager must attend. One possible strategy may be to assign other nurse(s), who know the individual well, to represent the health care needs of the individual during selected mini-staffing meetings.

9. Nursing Care Plans should be revised to include specific goals/objectives that are objective and measurable, as well as individualized interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed, and when they should be modified.

10. Documentation, particularly the SOAP charting as specified in the Health Care Guidelines, needs to be trained and monitored until nurses are implementing the process as it is intended.

11. Nurse case managers should ensure complete information to the individual's PST during the PSP process, including, but not limited to, findings of the nursing assessment, individual's response to planned interventions, and progress/lack of progress made toward desired health outcomes.

12. In addition to new employee orientation and annual mandated training, develop and conduct a rotating cycle of education and training in basic health care that is offered to direct care staff members.

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:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o EPSSLC Policy and Procedure: Adverse Drug Reaction Reporting, Revised 9/10 o EPSSLC: Drug Regimen Reviews, Revised 9/10 o EPSSLC: Clozapine Monitoring, 9/10 o EPSSLC: Excess/Returned Medications, 9/10 o EPSSLC Prospective Review of New Medication Orders, 9/10 o EPSSLC: After Hours Pharmacy, 11/17/10 o EPSSLC: Medication Errors, 9/10 o EPSSLC Medication Errors/Incidents, 11/09/09 o EPSSLC: Prescribing of Psychoactive Medications, Clinical Monitoring of Psychoactive Medications, 9/10 o EPSSLC: After Hours Pharmacy Stock, 9/10 o EPSSLC: Pretreatment Sedation Medications, 9/10 o EPSSLC: Medication Administration Guidelines, 9/09 o EPSSLC: Medication Administration Record, 9/10 o EPSSLC Policy #1.1.07: Pharmacy and Therapeutics Committee, Revised 3/10/06 o EPSSLC Lab Procedure Matrix o Pharmacy and Therapeutics Committee Meeting Minutes, dated 7/22/10, 8/26/10, 9/23/10, 10/28/10, 11/18/10, 12/30/10 o Pharmacy Intervention Form for the following individuals: • Individual #51, Individual #53, Individual #49, Individual #28, Individual #74, Individual #8, Individual #75, Individual #109, Individual #93,Individual #34, o Quarterly Drug Regimen Reviews forms for the following individuals: • Individual #126, Individual #42, Individual #178, Individual #157, Individual #79, Individual #24, Individual #14, Individual #96, Individual #75, Individual #99, Individual #61, Individual #8, Individual #161, Individual #83, Individual #88, Individual #122, Individual #164, Individual #74, Individual #113, Individual #100, Individual #16, Individual #23, Individual #6, Individual #11, Individual #102, Individual #17, Individual #15, Individual #73 o MOSES and DISCUS forms for the following individuals: • Individual #89, Individual, Individual, Individual #90, Individual #27, Individual #7, Individual #68, Individual #96, Individual #83, Individual #14, Individual #111, Individual #152, Individual #123, Individual #119, Individual #43, Individual #161, Individual #79, Individual #126, Individual #19, Individual #20, Individual #116, Individual #95, Individual #42, Individual #3, Individual #51, Individual #96, Individual #50 Individual #75,Individual #8, Individual #100, Individual #99, Individual #23, Individual #164,

	Individual #17, Individual #120, Individual #76, Individual #39, Individual #37, Individual #32 Individual #74, Individual #59, Individual #56 o Adverse Drug Reaction Reports for the following individuals: • Individual #24, Individual #14, Individual #122, Individual #126, Individual #8, Individual #74, Individual #120 o Drug Utilization Evaluations for the following drugs: • Reclast • Clozapine Interviews and Meetings Held: o Amista Salcido, Pharm.D., Pharmacy Director o Salvador Molina, DO, Medical Director o Eugenio Chavez-Rice, MD, Psychiatrist o Sandra DeLong, RN, Chief Nurse Executive o Elaine Lichter, RN, Quality Enhancement Nurse o Meeting with Pharmacy Director, Medical Director, Chief Nurse Executive, RN Manager, and QA Nurse Observations Conducted: o Tour of pharmacy o Informal observations of medication administration
	Facility Self-Assessment: The facility rated itself noncompliant in all areas of this provision of the Settlement Agreement with the exception of provisions N2, N7, and N8. Issues related to consistency of information reported in the drug regimens reviews, methodology of selection, and content of drug utilization evaluations, and a lack of through analysis of medication error data, have resulted in the monitoring team finding noncompliance with provision items N2, N7, and N8. The monitoring team concurs with the facility's assessment of noncompliance in the other areas.
	Summary of Monitor's Assessment: The pharmacy was staffed with a pharmacy director, one clinical pharmacist, one pharmacist, and pharmacy technicians. The pharmacy director reported directly to the medical director. There was progress noted in every provision since the previous onsite review. In many instances, however, programs and processes had been implemented in the weeks just prior to the onsite review resulting in limited data and/or information for review. The pharmacy began documentation of physician contact in September 2010 with the "Pharmacy Intervention Form." Drug regimen reviews were completed in a timely manner, but there were issues related to the content and consistency of data elements reported. There was also no mechanism in place to

	track physician implementation in those cases where there was agreement with pharmacy recommendations. The Polypharmacy Oversight Committee had one meeting prior to the onsite review and discussions of that meeting had not been formally documented. The meeting was also limited to those persons involved in the actual provision of medications. The DUE system was implemented, but the selection of drugs for review was not consistent with the recommendations of the Health Care Guidelines that specifically required that high use, high risk drugs be targeted initially. The revised ADR system had been implemented just weeks prior to the onsite visit which resulted in reporting of only one month of data. The MOSES and DISCUS rating tools were being completed in a timely manner. More problematic was the lack of any real physicians response as well as delays in physician response. Medication errors of omission remained problematic with hundreds of medications (not even including liquids, drops, and ointments) being returned to the pharmacy. The downward trend for the second half of the year culminated with a significant increase in returns during the month of December 2010. Although this information was reported to the facility's QA Department, there had been no apparent response to the problem based on a lack of any formal performance improvement projects.

#	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.	A prospective review was completed for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues. When issues related to these parameters were identified, the pharmacist completed a "Pharmacy Intervention Form." The physician was either called or the form was faxed to the medical office and the order was placed on hold pending further clarification. The facility policy on prospective review of new medication orders, however, did not include any references to this particular form. The pharmacy director stated that the form was implemented in September 2010. In cases of severe drug interactions, the order was placed on hold. The "Pharmacy Notification of Severe Drug Interaction Order" form was forwarded to the physician. The medication order was held until the physician reviewed the recommendations of the pharmacist and responded in writing. A request was made to review a sample of Pharmacy Intervention Forms and supporting documentation. Data from that sample are summarized in the table below:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		(table continued below)	

Individual	Report Date	Completion Date	Prescription Problem	Explanation
51	11/16/10	11/16/10	Allergy alert	Individual received Robitussin in past with no problem
53	11/16/10	11/16/10	Dosing issue	Clarification of Zithromax time
49	11/15/10	11/15/10	Dosing issue	Clarification on date and time of antibiotic start
28	11/3/10	11/3/10	Dosing issue	No strength written for Ducolax tablets and suppositories
74	11/12	11/12/10	Other	Confirm that Coumadin was to be discontinued. Verbal order to d/c Coumadin
8	11/15	11/15/10	Other	No stop date for silvadene cream
75	11/12	11/12/10	Duplication	Duplicate orders for omeprazole.
109	9/9/10	9/10/10	Duplication	Started on clonazepam when individual was on lorazepam. Lorazepam discontinued
8	11/15	11/16	Drug interaction	Decreased dose of clonazepam due to potential interaction with fluoxetine
34	11/19/10	11/19/10	Incomplete order	No stop date for silvadene ointment
89	11/16/10	11/16/10	Other: expense	Xopenex more expensive than albuterol; Xopenex d/c'ed
123	11/16/10	11/16/10	Other: expense	Xopenex more expensive than albuterol; Xopenex d/c'ed
96	11/10/10	11/10/10	Other	Vesicare is non-formulary; continue Flomax

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		The system captured the communications with the physician. The issues in the sample provided were relatively minor ones and all were resolved quickly. The consistency of this process will be examined during the next onsite review.	
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.	The clinical pharmacists completed quarterly drug regimen reviews. Overall, the drug regimen reviews were completed in a timely manner, addressed many relevant clinical issues, and provided some good recommendations. The monitoring team was provided copies of the "Quarterly Drug Regimen Review" (QDRR) form as well as the worksheets used to complete the form. The QDRR was filed in the record. It was noted that this form often lacked information that was obtained and documented on the worksheet. In many instances, this unreported information had clinical relevance (see examples below). The following are general concerns related to the drug regimen reviews: • The reports for individuals being treated for conditions, such as hyperlipidemia and hypothyroidism, did not always have the lab values on the form, which is the	Noncompliance

#	Provision	Assessment of Status	Compliance
		document submitted to the physician for review. Individuals treated for hypertension with diuretics did not always have the results of the metabolic panels reported. Important parameters for monitoring control of diabetes such as HbA1c, urinary microalbumin, were not consistently reported. The clinical pharmacist was very consistent in obtaining the data and reviewing it on the various worksheets. • Reference points were not always given. • It was sometimes difficult to clearly identify a specific recommendation that required action steps from comments since comments and recommendations were grouped together. The following is a synopsis of reviews that contained recommendations/comments with clinical significance. Also included are findings that were not included on the reporting form: Individual #157, 12/3/10 • The 3rd dose of the Hepatitis vaccination was past due and a recommendation was made to administer. • The individual was treated for osteopenia. The results of Vitamin D and BMD studies were not reported. • Individual saw Dr. Brower July 2010 due to history of seizures, but was on no AEDs. Seizures were reported in April 2010, September 2010, and December of 2010. • Individual was treated for hyperlipidemia, but lipid results were not reported. Results were noted on the worksheet. Individual #79, 12/2/10 • The individual was treated with olanzapine and quetiapine. Lipid results and HbA1c were reported. • The Vitamin D level and BMD done in 2005 were reported. Values were normal. Repeat studies were recommended. • A recommendation was made to obtain a urine micro albumin due to diagnosis of HTN, per lab matrix • A severe drug interaction was noted for enalapril and potassium. The potassium level from 10/10 was reported. There was no specific recommendation for monitoring electrolytes due to the use of diuretics. Individual #178, 11/8/10 • Individual was treated for hyperlipidemia, diabetes mellitus, osteoporosis, and hypertension. Lipid results, most recent BMD, and electrolytes were not	

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		reported. HbA1c levels were reported. • A CK level of 563 was reported for 6/16/10 and a recommendation made to repeat due to use of Simvastatin. • A recommendation was made to evaluate for appropriateness of ASA therapy due to the risk of coronary heart disease <u>Individual #96, 11/10/10</u> • It was documented that a BMD study on 4/29/09 showed osteoporosis. The individual was not on calcium supplement or bisphosphonates. • The EGD (8/21/09) showed non-erosive gastritis with a recommendation for antireflux treatment for life. The clinical pharmacist noted that this was not a contraindication for bisphosphonates therapy if gastritis was not severe. • The drug regimen included an order for ibuprofen 600 mg TID prn. The DRR did not provide any warning or comment for this medication, which had a start date of 4/07. The individual had gastritis in 2009. Also of significant importance was that the lab worksheet for this individual documented a ferritin of 6.9 in 5/10. This represented a significant iron deficient state, which was not discussed in the review, but which required follow-up if not already done. <u>Individual #126, 12/6/10</u> • Hyponatremia was noted on multiple labs reports. These were reported as an adverse drug reactions, but that was not noted in the DRR. • The individual was treated for osteoporosis and received quetiapine. Vitamin D levels, and BMD were not reported. Laboratory monitoring related to quetiapine was also not reported. Results for these studies were included on the worksheet. <u>Individual #42, 12/7/10</u> • The individual was treated for Vitamin D deficiency and hypothyroidism. Vitamin D and BMD results were reported. Serial lipid results were also reported with a recommendation to increase the Simvastatin dose. The TSH level was not reported. • The individual had a diagnosis of gastritis treated with multiple medications. In spite of that, he was prescribed ibuprofen 600 mg QID prn pain. There was no note related to the use of ibuprofen. <u>Individual #61, 11/17/10</u> • Monitoring of blood pressure, weight, and lipid panel were recommended. The individual was on Simvastatin and the last lipids were obtained in 2009. The date and results of the lipid panel were not included in the report.	

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		• No HbA1c was documented on the worksheet and no recommendation was made to obtain one. This was required per the lab matrix due to treatment with quetiapine and olanzapine. Individual #8, 11/12/10 • The individual was treated for hyperlipidemia and hypothyroidism, but lipid results were not reported. The TSH was reported. • Vitamin D levels and BMD results were reported, but reference ranges were not provided. • There was a recommendation to obtain a urine micro albumin due to the diagnosis of diabetes mellitus. • Hyponatremia was reported as a potential adverse drug reaction, but the sodium levels were not provided. The individual actually had documented hyponatremia (sodium 129,134) and this was reported as an adverse drug reaction. That information was not included in the DRR. • A borderline Vitamin D level of 31 was documented in 2005 with no follow-up. The last BMD was done in 2005. The lab matrix specified every two years. Individual #99, 11/8/10 • The Individual had an increased prolactin believed to be associated with medication paliperidone that was discontinued in July 2010. There was no follow-up level included in DRR after the medication was discontinued. • The individual was treated with quetiapine. The results of the CBC and TSH were not included in the report. A normal TSH was recorded in the worksheet. No HbA1c was documented on the worksheet. Individual #75, 11/15/10 • There was no documented seizure activity in 24 months • The results of the most recent BMD were reported along with the results of the 2005 BMD to document response to treatment. Individual #, 27, 12/1/10 • Three seizures were noted October 2010 – November 2010. Follow-up neurology appointment for medication adjustment 12/10. • Stat orders for diastat noted. • The individual was treated for osteoporosis with calcium, Vitamin Dd and alendronate. The Vitamin D level was reported in addition to the BMD studies done in 2005 and 2010. The BMD showed decreasing bone density. Individual #14, 12/1/10	

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		• A pharmacy consult was obtained due to weight gain believed to be associated with olanzapine. • The individual was treated for hyperlipidemia and hypothyroidism, but lipid results and TSH were not reported. The HbA1c was also not documented on the worksheet. <u>Individual #74</u> • The individual was treated for hypothyroidism, but no TSH level was reported. • The last BMD was completed in 2005. A repeat was due based on the facility's lab matrix. This recommendation was made in previous DRRs. The physician agreed with the recommendation, but a follow-up study was not done. • The individual had long standing chronic hyponatremia secondary to drugs. Hyponatremia was not reported. An ADR report was submitted in December 2010. • A recommendation to include BPH in the active problem list was made since the individual received multiple medications for this condition.	
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.	The quarterly drug regimen reviews included information on the use of polypharmacy, benzodiazepines, and anticholinergic burden. This was documented consistently in the most recent quarter of reviews. The Polypharmacy Oversight Committee held its first meeting on 12/13/10. Participants included the medical director, pharmacy director, clinical pharmacist, and the psychiatrist. The pharmacy director indicated that minutes from the meeting were not available. A copy of the agenda that included some hand written notes was provided to the monitoring team. There was no policy or operational procedure associated with this committee. A true oversight committee requires participation by persons other than the prescribing and dispensing parties. This should be addressed by the facility. The metabolic and endocrine risks were frequently documented in the drug regimen reviews but there was no standardization for this process and the information included varied. The lab procedure matrix did not include measurement of abdominal obesity, which is an important criteria in identifying metabolic syndrome. Compliance with safety monitoring for 2nd generation antipsychotics is discussed further in Section N7.	Noncompliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18	The format of the drug regimen reviews required prescribing providers to indicate agreement or disagreement with the recommendations of the pharmacist. If the physician disagreed, an explanation was required on the form. The physician agreed	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	with the pharmacist in almost every drug regimen review in the sample. There were, however, several instances in which the physician agreed with the recommendations, but failed to take action. This resulted in recommendations being repeated in drug regimen reviews. A review of the Pharmacy Intervention Forms demonstrated that physicians responded to the recommendations of the pharmacists at the point of drug prescription. The pharmacy director indicated that the department would begin tracking physician compliance with the current quarter of drug regimen reviews.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The record sample listed above was reviewed for the presence of MOSES and DISCUS scales, when appropriate. An additional random sample of tools was reviewed. All of the forms in the sample were adequately completed, signed, and dated. The physician review, however, occurred two months after completion in approximately half of the MOSES forms included in the sample. The DISCUS sample also presented similar issues related to timeliness of physician review. Further, neither tool appeared to be utilized by the neurologist and PCP based on a lack of documentation in clinical notes.	Noncompliance
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 revised its adverse drug reporting policy in November 2010. This policy provided a process for conducting an objective assessment of the occurrence of an adverse drug reaction. The Naranjo probability scale was included in the procedure. The policy did not provide any guidance on when an intense case analysis would be conducted or when the facility's critical incident/sentinel event policy was activated. The first reporting of adverse drug reactions in the P&T Committee was noted in the minutes of 12/3/10. Information on the adverse drug reactions was taken from the P&T minutes dated 12/30/10, the ADR reporting form, and discussions with the pharmacy director. This information is presented in the table below.	Noncompliance

Individual	Report Date	Medication	Reaction	Explanation
24	12/2/10	Terbinafine	Elevated liver function test	• Discontinue medication • Recheck liver enzymes in 1-2 weeks • Check US of liver
14	11/19/10	Olanzapine	Weight gain	• D/C med • Monitor weights

#	Provision	Assessment of Status	Compliance
		<table><tr><td>122</td><td>12/3/10</td><td>Valproic acid</td><td>Elevated ammonia and diarrhea</td><td>Taper off VA</td></tr><tr><td>126</td><td>12/14/10</td><td>Oxcarbazepine</td><td>Hyponatremia</td><td>Taper off med</td></tr><tr><td>8</td><td>12/15/10</td><td>Trileptal</td><td>Hyponatremia</td><td>Hyponatremia predated trileptal. Taper off med</td></tr><tr><td>74</td><td>12/30/10</td><td>Trileptal</td><td>Hyponatremia</td><td>Long standing hyponatremia. Taper off med</td></tr><tr><td>120</td><td>12/31/10/10</td><td>Haldol</td><td>Elevated prolactin</td><td>Haldol discontinued</td></tr></table> P&T committee minutes, dated 10/28/10, documented that all nurses and direct care professionals were to be trained on the ADR system. Other allied health professionals did not receive formal training. Therapists and others with the potential to detect adverse drug reactions should also be trained. The ADR system contained the essential components. The determinations of probability were appropriate based on the information reported. The next step in the ADR system is to systematically collect data and perform data analysis to look for patterns and trends related to individuals or clusters of individuals. Emphasis should be placed on identifying preventable ADRs, assessing prescribing patterns of practitioners, and monitoring practices. Data should be used to provide education to healthcare professionals. This system must be incorporated into the facility's quality assurance initiatives. Also, in the process of completing drug regimen reviews, it is important to note and report ADRs.	
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	At the time of the onsite review, the facility had completed drug utilization evaluations on Reclast and Clozapine. Some of the information from these two DUEs is summarized below. <u>Reclast</u> Prospective DUR – Reclast Referrals – August 2010 to October 2010 The objective of the review was to evaluate for alternative osteoporosis treatment options in the select population that cannot tolerate current treatment strategies. • Contraindications, precautions, benefits and cost-effectiveness of Reclast were examined. • Seven individuals identified through quarterly drug regimen reviews were determined to be candidates for Reclast. • The necessary documents, including the medical necessity statements were	Noncompliance

#	Provision	Assessment of Status	Compliance
	a separate monitoring plan.	prepared for those seven individuals. Clozapine Retrospective/Prospective DUR – Dual Antipsychotics – November 2010 The objective of the review was to evaluate the indication behind dual antipsychotics and monitoring. • Clozapine was cited as the standard of care for those individuals with refractory schizophrenia who do not respond to at least two trials of an antipsychotic. Guidelines for the use of clonazepam were provided along with the Texas Medication Algorithm Project. • Seven individuals were identified through the November 2010 psychoactive medication report. • All seven individuals had an appropriate indication for use. • Safety monitoring was mostly appropriate with two of the seven (29%) not having annual fasting lipid panel and one of the seven (14%) did not have an annual TSH level. All other monitoring and side effect monitoring was appropriate. • Five of the seven individuals were considered to be candidates for clozapine. Drug utilization reviews are appropriate to monitor: • individual drugs, • drug classes, and • drug use in specific diseases. Further, DUEs may be prospective, concurrent, or retrospective. The Health Care Guidelines stated that high risk and high use drugs should be given priority for drug utilization evaluations. Although both medications targeted by the DUEs at EPSSLC were valid and represented clinical challenges, the population impact was approximately 14 individuals. DUEs should typically be first targeted to those drugs that have the highest use or represent the greatest risk to the population. The findings of the clozapine review provided particularly valuable information that had the potential to provide the next steps in the development of the DUE process for the facility. It was identified that safety monitoring represented a compliance issue. Further analysis of this issue should be investigated by completing concurrent DUEs on all individuals receiving second-generation antipsychotics. Process and outcome indicators have essentially been identified in the lab matrix.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>A drug calendar was provided and included month of review, drug, intervention, and follow-up. The interventions and follow-up were provided on the calendar. The methodology of the DUE was discussed with the pharmacy director because it appeared that the interventions and follow-up had already been determined prior to completion of the reviews. Interventions are typically the activities implemented by the DUE Committee to correct problems that are identified during the DUE process, not prior to the process.</td><td></td></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>The facility had taken several steps in order to address the problem of medication errors. Medications returned to the pharmacy were being counted and reconciled and, in that regard, progress had been made since the July 2010 monitoring team onsite visit.

Medications that failed to be reconciled, due to hospitalization, leave of absence, and so forth were counted as errors of omission. Liquids, ointments and drops were not included in the return counts. The reconciliation rate was approximately 50%.

<table>
<tr><th colspan="6">Number of Medications
Returned To Pharmacy 2010</th></tr>
<tr><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>471</td><td>435</td><td>242</td><td>205</td><td>356</td><td>544</td></tr>
</table>

Corrective actions were focused on resolution of omissions and included:
• One to one training with nurses by the RN managers.
• Focusing on nursing accountability – nurses were required to count meds each shift to ensure early identification of errors.
• Changes in medication administration times.
• Changes in medication delivery.

While the reconciliation process appeared to produce reductions in return rates, that progress was not sustained, based on the December 2010 data. The nursing department had devoted significant resources to the reconciliation efforts, but that time would likely be better spent in other areas, such as direct care.

In discussions with the QA Nurse, Chief Nurse Executive, and RN Manager, it was clear that the QA Department had not been actively involved in a serious problem that translated into a substantial number of medications repetitively not being administered to individuals living at the facility. This continued problem represented a huge opportunity for improvement for the agency if the correct performance improvement methodology is utilized. Also see section M6 of this report.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Recommendations:

1. The Quarterly Drug Regimen Review form should provide additional data. If an individual receives medication for a condition and there is laboratory monitoring for that condition, the values should be reported. Individuals being treated with statins should have LFTs and lipid panel results reported for each review. Ordering of the labs would be per lab matrix or as clinically indicated.

2. Physician signatures on the QDDR, MOSES, and DISCUS forms should be dated.

3. Physician compliance with recommendations should be tracked. If the physician agrees with the recommendation, there should be evidence that the recommendation has been implemented.

4. Training for the ADR system should be expanded to include all allied health professionals.

5. The drug use evaluations should be targeted at those drugs that have the greatest impact on the people living at the facility. This can be achieved by reviewing drugs most commonly prescribed and those with a high-risk index such as drugs with a low therapeutic index or drugs known to cause side effects.

6. Completed DUEs should be presented to the P&T Committee. Problems identified require a corrective action plan that includes the problem, the actions to be taken, responsible parties and timelines for completion. The P&T Chair should have responsibility for following the corrective actions through to completion.

7. The polypharmacy oversight committee should include membership in addition to those who prescribe and dispense.

8. The polypharmacy oversight committee might consider the creation of an additional metric to indicate the number of individuals for whom active medication titrations are in progress, but not yet completed. This would be a listing in addition to the lists of individuals who meet the criteria for polypharmacy as per this provision item and any other relevant facility or state policies (see section J11).

9. The Quality Assurance Department should take an active role in addressing the issue of medication variances.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o Clinical Staff list and PNMT members o CVs for Eric Herrera, PT, Henry Kielb, MS, CCC/SLP, Donna Rice, RD/LD, Susan Acosta, PT, DPT o State license verification for clinical staff o Continuing Education documentation for clinical staff o PNMT initial training outline o PNMT draft policy, draft assessment format, and assessment sample (EPSSLC submitted the old Nutritional Management policy) o At Risk Individuals, Policy #006, October 2010 o Risk Guidelines Draft o At Risk Policy Frequently Asked Questions o Aspiration Pneumonia/ Enteral Nutrition Evaluation o Aspiration Triggers Data Sheet o Quick Start for Risk Process o Risk Process Flowchart o EPSSLC POI and Supplement o Presentation Books for Sections O, P and R o PNMP Committee meeting minutes (7/7/10, 7/14/10, 8/4/10, 8/11/10, 9/1/10,9/8/10, 9/22/10, 10/6/10, 10/13/10 and 10/27/10) o Individual NMC Reports o NMC Screening Tool o HST meeting minutes o HST Risk Assessment risk lists o Hospital Leaves 1/1/09 and 12/3/10 o Emergency Room visits o PT Database o List of adaptive mealtime equipment o Dining Plan training sheets submitted o NEO Training modules with checklists and competency tests o Dysphagia, food textures and mealtime training materials o Trial PNMP Risk Monitoring spreadsheet o Yearly NMT spreadsheet o NMC review spreadsheet o Aspiration Risk Review spreadsheet o Dining Plans submitted o Dining Plan template

	o Guidelines for PNMP monitoring and Mealtime Observations o Clinical Dysphagia Evaluations and MBSS spreadsheet o List of individuals monitored in October and November 2010 o Requested or Observed Monitoring Form o PNMP Monitoring Form o Mealtime Monitoring Form o Mealtime Observation Sheet o Completed monitoring sheets submitted o List of individuals with PNM needs o Completed Requested or Observed Monitoring forms submitted o OT/PT Referral Source spreadsheet o OT Assistive Equipment List o RTT3 Facilitator Form o Work Order spreadsheet o PNMT Evaluation template o List of individuals on modified diets/thickened liquids o Food Texture/Liquid Consistency Downgrades o List of Fall Incidents 8/1/10 to 10/31/10 o Injuries Fracture-Suture-Dermabond 10/1/09 – 10/31/10 o Weights with BMI >30 o Weights with BMI <20 o Individuals with unplanned weight loss of 10% or greater in last six months o List of individuals with enteral nutrition o Decubiti spreadsheet o Choking Incidents 12/6/08 – 11/23/10 o List of individuals with poor oral hygiene 1/22/10 o List of Individuals with Wheelchair as Primary Mobility o List of Individuals with Wheelchair for Transport o PNMPs submitted o List of individuals with Dysphagia o List of individuals with Pneumonia o GT Orders 11/23/10 o Deaths July 2010 – 11/24/10 o Documentation for individuals provided therapeutic feedings: • Individual #115, Individual #93 and Individual #71 o Follow-up documentation by SLP for swallowing incidents for the following: • Individual #13, Individual #104, Individual #39, Individual #83 and Individual #132. o Personal Records for sample of individuals including: Comprehensive Nursing Assessments, Nursing Quarterlies, current list of medications, PNMPs for last 12 months, Dining Plans for last 12 months, contents Habilitation Therapy tab, Annual Nutrition Assessments and quarterlies, PSP and addendums, PSP quarterly reviews, Incident/Injury reports for fractures, choking or swallowing events, hospitalizations records, MBSS reports and follow-up by SLP, contents Gastroenterology

tab, contents Orthopedics tab, Integrated Progress Notes from 1/1/10 to 1/4/11 and, monitoring sheets completed for last six months as submitted for:

- Individual #39, Individual #84, Individual #97, Individual #115, Individual #15, Individual #116, Individual #178, Individual #103, Individual #119, Individual #123, Individual #152, Individual #78, Individual #33, Individual #113, Individual #28, Individual #74, Individual #4, Individual #13, Individual #132, Individual #12 and Individual #73

Interviews and Meetings Held:

- Anderson Hicks, OTR, Director of Habilitation Therapies
- Susan Acosta, PT, DPT
- Eric Herrera, PT
- Jessica Cordova, PT
- Sandra Moreno, PTA
- Henry Kielb, MA, CCC-SLP
- Bahola Puentes-Polo, MS, CCC-SLP
- Donna Rice, RD/LD
- Mary Ann Clark, RN
- Clara Aguilera, COTA
- Alfredo Diaz De Leon, COTA
- Various Supervisors and Direct Support Staff
- Meeting with OTs and PTs
- Meeting with SLPs
- PNMPCs
- PNMT meetings for Individual #84 and Individual #115
- PST meeting for Individual #43

Observations Conducted:

- Living areas
- Dining rooms
- Day Programs
- Habilitation Therapies clinic areas

Facility Self-Assessment:

EPSSLC's self-assessment rated noncompliance for all items of this provision. Systems were in the process of development particularly the new PNMT process. This self-assessment was consistent with the monitoring team's assessment of noncompliance.

Summary of Monitor's Assessment:

A notable area of improvement was in the area of transfers, though refreshers related to staff body mechanics was an ongoing need. Improvements were also evident during mealtimes, though there

	continued to be concerns noted during observations by the monitoring team. Monitoring had increased and training as well as validation of monitors had been ongoing, but even the internal analysis of compliance with the process identified numerous errors. PNMPCs were observed to be monitoring, but did not identify several issues related to diet texture, liquid consistency, or implementation of the Dining Plan in one home and did not intervene appropriately. EPSSLC is congratulated on their efforts to self-assess and use the feedback to guide training, but the process was new and ongoing review was indicated. The PNMT process was initiated, but there was no assigned OT or nurse because these staff had recently resigned. There will be a significant period of growth as they attempt to clearly establish roles and responsibilities. The initial meetings observed were examples of these growing pains and, in one case, the PNMT actually usurped what should have been PST roles and this will need to be clarified. The PNMT should take on a role of assessment and analysis and this should not be limited to a meeting only format. Extensive assessment, staff interview, and observation will be critical to the successful design of appropriate interventions. The PNMT must collaborate and be well integrated with the PST, but should not take on PST functions. The PNMT is an adjunct resource, not intended to replace the PST process. There was a need for a well outlined agenda to keep the meetings on track and moving along. This process in conjunction with the newly implemented At Risk Individuals policy will require extensive review during future onsite visits by the monitoring team.

#	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	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** EPSSLC had initiated the new process for the Physical Nutritional Management Team (PNMT). The intended function of the team was to address individuals whose identified health status placed them at a high risk of potential or actual injury and/or illness. The initial step in this process was to identify PNMT members. The core members of the newly established Physical Nutritional Management Team (PNMT) included the following: • Susan Acosta, PT, DPT, Chairperson • Jessica Cordova, PT (alternate) • Henry Kielb, MA, CCC/SLP • Bahola Puentes-Polo, MS, CCC-SLP • Donna Rice, RD/LD • Adriana Rascon Lopez, RD/LD Each of these clinicians was responsible for a large caseload requiring them to complete assessments, attend PSP meetings, develop intervention plans, and provide monitoring and review. The dietitians worked part time only and were available approximately one	Noncompliance

#	Provision	Assessment of Status	Compliance
	PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional 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.	or two days per week only. None of these clinicians were designated as only assigned to the PNMT. There were approximately 135 (100%) of individuals identified with PNM needs per the list submitted. It was of concern to the monitoring team as to how these clinicians would be able to meet all of the roles and responsibilities outlined for them, adequately meet the PNM needs of the individuals at EPSSLC, and appropriately address the issues of those at highest risk through the PNMT. The nurse originally assigned as a member had resigned as well as the OT. At the time of this review, these positions had not been filled though Anderson Hicks, OTR, Director of Habilitation Therapies, attended some of the meetings and Mary Ann Clark, RN, was serving as the nurse on the PNMT temporarily. Additional adjunct members included nurse case managers, QMRPs, PNMPCs, psychology, and direct support staff as indicated depending on which individual was to be reviewed by the PNMT. Evidence of current licenses was submitted for all team members except Mary Ann Clark. CVs were submitted for Mr. Kielb, Ms. Rice, and Ms. Acosta as well as for the nurse who had resigned. No other CVs were submitted as requested. Per the CVs, there was only one listing for continuing education for Mr. Kielb and this pertained to Vital Stim Dysphagia Therapy. No continuing education was listed on Donna Rice's CV. Ms. Acosta had completed a clinical doctorate in physical therapy and listed DADS webinars and the annual conference as well as a course related to dysphagia. Other evidence of continuing education submitted since the previous review was related to NMT/ PNMP/Equipment Webinars related to PNM and provided by DADS. This included the following: • Nutritional Management Clinical Assessment Technologies (7/30/10) • PNMT and Wound Care Investigation (8/13/10) • Seating and Positioning for Dysphagia (9/1/10) • Monitoring and Training (10/27/10) These were attended by some of the PNMT members as follows: • Susan Acosta: 7/30/10 and 10/27/10 • Jessica Cordova: 8/13/10, 9/1/10 and 10/27/10 • Henry Kielb: 7/30/10, 8/13/10, 9/1/10 and 10/27/10 • Bahola Puentes-Polo: 7/30/10 and 8/13/10 • Anderson Hicks: 7/30/10, 8/13/10, 9/1/10 and 10/27/10 The OT team member had attended all of these sessions prior to his resignation. The RN team member had attended one session on 10/27/10 prior to her resignation and the dietitians had not attended any of the sessions. Other staff had attended including nursing, therapy assistants, and technicians, though they were not designated members of	

#	Provision	Assessment of Status	Compliance
		the PNMT. There was no further evidence of continuing education for other team members. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The previous PNMP Committee meetings had been held routinely since the previous review on 7/7/10, 7/14/10, 8/4/10, 8/11/10, 9/1/10, 9/8/10, 9/22/10, 10/6/10, 10/13/10, and 10/27/10. The number of individuals reviewed during each meeting ranged from 10 to 53. Approximately 123 individuals had been reviewed one or more times by the committee since the previous onsite visit by the monitoring team. Number of times individuals were reviewed by the committee was as follows: Number of Reviews / Number of Individuals: 1 – 26; 2 – 27; 3 – 27; 4 – 22; 5 – 17; 6 – 3; 7 – 1 • Individual #84 was reviewed seven times. Three others reviewed six times included Individual #115, Individual #78 and Individual #152. Each of these individuals was listed at high risk. • There were a number of individuals who were listed at medium risk, but were only seen one time during that period (Individual #183, Individual #125, Individual #20, Individual #21, Individual #2, Individual #31, Individual #83 and Individual #127). • Others who were at low risk were seen two or more times with no change in risk level, including: Individual #79 (3), Individual #89 (4), Individual #123 (2), Individual #124 (2), Individual #45 (3), Individual #50 (2), Individual #104 (3), Individual #107 (3), Individual #108 (3), Individual #68 (2), Individual #117 (3), Individual #35 (2), Individual #36 (3), Individual #38 (4), Individual #37 (2), Individual #77 (2), Individual #17 (3), Individual #60 (4), Individual #65 (3), Individual #9 (3), Individual #54 (4), Individual #157 (5), Individual #164 (2), and Individual #188 (4). With the newly implemented system, the PNMT met more frequently and yet reviewed	

Nested table (within Assessment of Status):

Number of Reviews	Number of Individuals
1	26
2	27
3	27
4	22
5	17
6	3
7	1

#	Provision	Assessment of Status	Compliance
		fewer individuals, though in a more in-depth manner. Previously, the committee had reviewed so many individuals they were not able to address any concerns in a thorough comprehensive manner. The fewer number of individuals reviewed will now permit greater problem-solving and improved integration of a comprehensive PNM assessment. The new PNMT will be challenged as this new system grows, however, to manage their existing caseloads and their additional roles and responsibilities as PNMT members. At the time of this review the PNMT had met regarding these individuals. • Individual #93 (10/28, 11/2 and 11/16/10) • Individual #84 (11/4, 11/9, 11/16, and 11/18/10) • Individual #97 (11/9, 11/12 and 11/23/10) They also met regarding Individual #84 and Individual #115 during the week of the onsite review by the monitoring team. The team's ability to appropriately address change in status, assessments, clinical data, and monitoring results in a timely and comprehensive manner will need to be further evaluated in future onsite reviews.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management	**Standard: A process is in place that identifies individuals with PNM concerns.** Per a list submitted for this onsite review, there were 135 individuals identified with PNM needs. At this time, it was a standard practice that all individuals with any type of equipment or who had any need for specialized instructions were provided a PNMP. Per the PNMPs submitted, this included individuals who were identified as independent with mobility, transfers, and positioning. Some had no precautions related to physical management with little to no adaptive mealtime equipment. Some had eyeglasses. Each had the standard communication book or new individual book provided to everyone living at EPSSLC. Some examples included Individual #132, Individual #37, Individual #120 and Individual #51 who were identified at low PNM risk by the PNMP committee. This also included Individual #56, Individual #109, and Individual #73 who were identified at medium PNM risk by the committee. Also see comments at O3 below. A new policy and process used to establish health risk levels had recently been implemented statewide. The goal was to have discussions of risk occur during each individual's PST meetings. Nevertheless, a PST meeting was held at EPSSLC during the week of the onsite review for Individual #43 solely for the purpose of health risk assessment and assignment of specific health risk levels in the state-designated areas. The team struggled with its understanding that risk would still be present even though intervention plans were in place. Some team members advised the PST of the risk level	Noncompliance

#	Provision	Assessment of Status	Compliance
	problems to identify the causes of such problems.	rather than clearly and concisely presenting objective data for discussion with the resulting establishment, via team consensus, of risk level designation. The individual's mother offered extremely valuable information that influenced the discussion and ultimately the risk designations. It was of concern that the PST would likely not have discussed some of the mother's issues at all and, as a result, would have come up with different designations and supports. One team member stated several times that certain information could not be obtained because the individual did not communicate or that she presented with cognitive limitations. The PSTs will require significant clinical instruction regarding risk assessment and real time modeling by state leaders (as is the plan) to effectively implement this new policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The new statewide system to identify and manage individuals at risk was outlined in policy number 006.1, At Risk Individuals, with an implementation date of 1/1/11. This policy was intended to identify individuals who were at risk for illness or injury as well as to identify actions and supports to mitigate the risks. The PST was to initiate assessment upon change in status for any individual to examine the existing support plans to ensure the appropriate measures were in place. The PNMT was defined as follows per this policy: A team of specialists with knowledge and expertise in the development of Physical Nutritional Management Plans who meet to provide comprehensive assessment and determine appropriate intervention for persons whose identified health status places them at highest risk for potential or actual injury and/or illness. Members of the PNMT include the following disciplines: registered nurse, physical therapist, occupational therapist, dietician, speech pathologist and others as needed. All core team members should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. As requested the team shall include primary care providers, nursing case managers, therapists, psychologists, QMRPs, home supervisors, facility support services staff and others as needed. The PST was to refer individuals at high risk to the PNMT who were not stable and for whom the PST required assistance in developing a plan. The PNMT was to begin assessment within five working days of referral to determine possible causes for the change in status, to analyze assessment findings, integrate recommendations and to propose an action plan with measurable goals and outcomes. Existing risk concerns included the following based on the documents submitted by the facility to the monitoring team:	

#	Provision	Assessment of Status	Compliance
		Choking There were at least 24 individuals identified at high risk of choking. Another 54 individuals were listed with a medium risk for choking. A list submitted reported that there were two choking incidents from 12/6/08 through 11/23/10 for Individual #13 (12/6/08) and Individual #57 (5/5/09). Each of these individuals was listed at high risk for choking. A Code Blue was called for Individual #57 and he was sent to the emergency room. The event on 12/6/08 for Individual #13 was described by the SLP as "life threatening" and the Heimlich was not successful and required resuscitation by EMTs. The SLP described another event for Individual #13 while eating on his bed on 7/23/10 involving a Code Blue with oxygen saturation levels at 30 and 40 before he was resuscitated and hospitalized until 7/30/10. It was not clear why this event was not listed as a choking event on the list submitted. There was no special meeting of the PNMP Committee after this event nor was he reviewed at the two meetings held subsequent to this event. The choking incident that occurred at school on 5/7/09 for Individual #69 was also not listed. A Clinical Dysphagia Evaluation dated 8/18/10 for Individual #39 described a choking event on 8/17/10 while eating tortillas. The SLP who was present described that Individual #39 was in "obvious distress" trying to cough but could not "fully produce a cough." The SLP instructed the direct staff to give him a sip of Koolaid which produced "wretching sounds" and when his head was brought forward he was able to clear the food. Individual #39 was listed at low risk for choking and this incident was not listed as a choking event on the list submitted. He was reviewed by the PNMP committee on 9/1/10. An event for Individual #132 was described as choking on a piece of chicken on 11/3/10. He was listed at low risk for choking and this was not listed as a choking incident on the list submitted. He was not reviewed by the PNMP committee or PNMT per the documentation submitted. Other incidents were described for Individual #104 and Individual #83, who were designated as low and medium risk respectively. The event on 11/16/10 for Individual #104 was not reviewed by the PNMP committee or the PNMT. The incident for Individual #83 occurred on 3/3/10 and was not included in the current documentation. Incident reports and follow-up documentation were requested for all swallowing events. Only consult reports by the SLP were submitted and some limited progress notes, but no incident reports. Osteoporosis/Osteopenia There were 22 individuals considered at high risk for osteoporosis or osteopenia and approximately 67 individuals considered to be at medium risk. There were three individuals listed with fractures since 10/1/09 through 10/31/10 and included Individual #84 (10/22/09), Individual #116 (5/26/10), and Individual #15 (9/7/10), each of whom had a diagnosis of osteoporosis and/or osteopenia. Only	

#	Provision	Assessment of Status	Compliance
		Individual #116 and Individual #84 were identified at high risk for osteoporosis. <u>Falls</u>: There were only seven individuals considered to be at high risk for fall injury, however, there were a number of other individuals listed with three or more slip, trip, or fall events in a three month period who were not identified as being at risk. Some examples included: • Individual #14: Experienced three non-serious slip/trip/fall events during the three-month period. • Individual #90: Experienced three non-serious slip/trip/fall events during the three month period. There had been three additional events resulting in a concussion (11/3/09) and sutures 11/3/09 and 11/4/09) during the previous 12 months. • Individual #111: Experienced three non-serious slip/trip/fall events during the three month period though she was also listed with a dislocation on another list on the same date as one of the falls documented (8/7/10). • Individual #116: Experienced three non-serious slip/trip/fall events during the three-month period though she was listed with a fracture related to an earlier fall on 5/26/10. • Individual #30: Experienced one serious, one non-serious, and two other slip/trip/fall events during the three-month period that did not require treatment. • Individual #83: Experienced three non-serious slip/trip/fall events during the three-month period. • Individual #47: Experienced three non-serious slip/trip/fall events during the three-month period. <u>Aspiration/Aspiration Pneumonia</u> There were at least 24 individuals identified at high risk of aspiration and another 55 individuals considered to be a medium risk of aspiration. There were at least 49 individuals listed with dysphagia, most of whom also presented with gastroesophageal reflux and aspiration risk. There were 16 individuals listed who received enteral nutrition: Individual #92, Individual #46, Individual #103, Individual #155, Individual #125, Individual #97, Individual #113, Individual #71, Individual #114, Individual #1, Individual #93, Individual #2, Individual #72, Individual #54, Individual #57 and Individual #115. Individual #54, Individual #114, and Individual #1 received enteral intake on a PRN basis only. Individual #103, Individual #125, Individual #97, Individual #113, Individual #93, and Individual #71 received continuous tube feedings while the others received bolus	

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		feedings. Individual #46, Individual #57, Individual #71, Individual #113, Individual #115, Individual #1, Individual #2, Individual #93, and Individual #97 were identified at high risk for aspiration. Others were identified at medium risk. There were nine individuals who had a diagnosis of pneumonia since 2/17/10 through 10/25/10, categorized as aspiration pneumonia for Individual #92 on 9/10/10 and twice for Individual #97 on 4/27/10 and 10/25/10. One episode for Individual #84 was listed as bacterial pneumonia but the other six incidents were not categorized with regard to type. Most of these individuals were listed at high risk for aspiration except for Individual #10 (medium), Individual #178 (low) , and Individual #92 (medium). It was of concern that Individual #92 had experienced a fairly recent incident of aspiration pneumonia on 9/10/10, yet was considered only to be at medium risk for aspiration. Both she and Individual #97 were enterally nourished. Each of the others received a modified diet orally. <u>Weight Loss/Gain</u> There were 20 individuals listed with BMIs at 30 or greater placing them in the category of obese. Three of these had BMIs of over 40 (Individual #122, Individual #178, and Individual #16). Only Individual #178 was considered to be at high risk for weight issues. There were 16 individuals with a BMI under 20, at least 10 of whom were in the underweight category with a BMI of less than 18.5. There were 28 individuals who had an unplanned weight loss of 10% or more in six months. Only three individuals had been listed at high risk (Individual #13, Individual #15, and Individual #1). Three of these were also in the underweight category with BMIs as follows: Individual #21 (17.5), Individual #118 (14.9) and Individual #28 (16) and were not considered to be at high risk for weight issues. At least five received enteral nutrition. <u>Pressure Ulcers</u> There were seven individuals considered to be at high risk for skin integrity concerns. At least 12 individuals who had actual occurrences of pressure ulcers were included on the Decubiti Spreadsheet submitted. Only three of them were identified at high risk for skin integrity concerns (Individual #97, Individual #15, and Individual #74). Individual #97 was listed with two Stage II ulcers (sacrum and coccyx), both resolved on 1/1/10 and 11/1/10, respectively. Individual #15 was listed with a Stage I and II ulcer on his left posterior thigh, resolved on 9/1/10. Individual #74 presented with unstageable ulcers on both heels, resolved on 10/1/10. Individual #41 was listed with two Stage II ulcers (sacral cleft and left posterior calf). Individual #191 was listed with a Stage IV ulcer on his coccyx at admission on 7/20/10, requiring surgical repair on 9/1/10. Two additional Stage I and II ulcers were reported on each heel. Individual #113 was listed with an unresolved ulcer on his left buttock since	

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		7/1/10. None was listed at high risk for skin integrity concerns. Individual #41 was deceased at the time of this review and Individual #191 was excluded from the health risk lists though he was on the current census list. Eight of the individuals who had issues of skin integrity in the last year were seated in a wheelchair as their primary mean of mobility. Two others were listed with a wheelchair for transport only. Medical Concerns: The hospitalization list with treatment and diagnosis submitted was for the year 2009 only. Another list for the last two years that included the year 2010 did not include diagnosis, but rather dates of hospitalization only. Consequently, the monitoring team was not able to analyze this aspect with regard to PNM concerns. There were 17 individuals who had been hospitalized three or more times in the last two years. Many of these were the same individuals identified above with one or more PNM concerns including, Individual #15, Individual #57, Individual #1, Individual #4, Individual #178, Individual #71, Individual #72, Individual #113, Individual #115, and Individual #97. Of the sample reviewed by the monitoring team, the following individuals had been hospitalized in the last year for PNM-related concerns: • Individual #178: pyelonephritis secondary to E. coli, pansensitive and severe fecal impaction (7/7/10). He also had an existing diagnosis of diabetes mellitus Type 2 and cervical spine compression status post decompression procedure in June 2010. • Individual #97: infection of the PEG tube site with cellulitis (11/22/10) and aspiration pneumonia (4/27/10 and 10/25/10). • Individual #15: two fractures in left femur (9/7/10). • Individual #113: UTI (blood cultures positive for coagulase-negative Staph sensitive only to vancomycin (11/26/10). Dehydration and vomiting (10/27/10). Previous EGD revealed severe erosive esophagitis with distal erosions encompassing the entire esophagus, also gastritis with erosions in both the stomach and duodenum. • Individual #4: UTI (10/13/10). Review of this process will be necessary as the new systems for Health Risk Assessment and PNMT review are implemented during the upcoming months. The current system of risk identification continued to be inconsistent and the monitoring team expects that these issues will be resolved as the new systems are implemented in the near future.	
O3	Commencing within six months of	**Standard: All persons identified as being at risk and requiring PNM supports are**	Noncompliance

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	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.	**provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** There were approximately 135 of individuals identified with PNM needs and all (100%) had PNMPs. The provision of PNMPs, however, was not necessarily based on risk. There were approximately 10 individuals who were independent and had little to no equipment needs beyond the Communication Book and Individual Book that were provided to everyone at the facility. While it was questionable as to whether they required a plan, it could potentially be more confusing to staff if only a few individuals did not have a plan. As described above, the previous facility-wide system of risk assessment and designation did not appear to consider actual incidence in its assessment and was not well integrated with the PSP, PNMPs, and PNMP Committee reviews. The new system, however, was intended to address all of this and to ensure improved integration of this process with the PST. The new PNMT was intended to be focused on those at high risk and for whom the PST required assistance with regard to assessment and development of intervention and support plans. Further assessment of this process will be needed in future reviews by the monitoring team. The PNMP contained information related to the focus, assistive equipment, communication, PNM risks, mobility, transfers, movement techniques, and positioning, as well as mealtime instructions. The plans provided a revision date and an arrow before a statement in the plan was an indication that a change had been made in that particular area. All the plans reviewed were current within the last 12 months. The monitoring team considered the following criteria in choosing 22 individuals for a record sample: • Emergency Room visits • Hospitalizations • NMT Committee meeting documentation • Individuals with active pressure ulcer within the last six months • Individuals with severe dysphagia • Individuals with chronic constipation or who experienced fecal impaction within the last six 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 six months • Individuals with a diagnosis of aspiration pneumonia • Individuals who have experienced significant falls related to transfers and/or	

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		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 The individuals selected included Individual #39, Individual #84, Individual #97, Individual #115, Individual #15, Individual #116, Individual #178, Individual #103, Individual #191, Individual #119, Individual #123, Individual #152, Individual #78, Individual #33, Individual #113, Individual #28, Individual #74, Individual #4, Individual #13, Individual #132, Individual #12 and Individual #73. As described above, Individual #191, had not been assessed by Habilitation Therapies though he was listed on the census list submitted. No records were submitted for him. The PNMPs submitted for each of the 21 individuals for whom personal records were submitted were reviewed with findings as follows: • PNMPs were submitted for 21 of 21 individuals included in the sample. The sample size for PNMPs was considered to be 21 for the purposes of this review. • PNMPs for 21 of 21 individuals in the sample (100%) were current within the last 12 months. • In 21 of 21 of PNMPs reviewed (100%), mobility was addressed. • In five of the 12 PNMPs reviewed (42%) for individuals who used a wheelchair, general positioning instructions for wheelchair though most of these were very limited. • In 21 of 21 PNMPs reviewed (100%), the type of transfer was included or there was a statement indicating that the individual was able to transfer without assistance. • In 12 of 21 PNMPs reviewed (58%), the PNMP listed bathing instructions. Bathing strategies were not addressed for nine individuals who did not have specialized bathing equipment listed. Five of these were described as independent with mobility and transfers. • In 19 of 21 PNMPs reviewed (91%), handling precautions or instructions were included. Often the only instructions were to use caution due to "brittle bones." • In 21of 21 PNMPs reviewed (100%), instructions related to mealtime were included, though there were three who received their nutrition via gastrostomy tube and as such oral intake instructions were not indicated. Individual #115 had a PNMP revised on 12/31/10 to include instructions for oral intake. At the time of this review, the SLP indicated that only staff who had been specifically trained	

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		to assist Individual #115 were permitted to provide any oral intake. There were no instructions, however, in his PNMP or in his Dining Plan regarding this. Instructions were of a general nature, lacking specificity for bite size, amount of oral intake permitted, and the frequency of pleasure mealtime intake. Instructions contained a significant amount of technical jargon and were not user friendly. • In 21 of 21 PNMPs reviewed (100%), diet orders for food texture were included, including those who received only non-oral intake. • There were 18 individuals who received liquids orally. Of those, the liquid consistency was not specified for nine individuals. It may have been in those cases that they received regular thin liquids, but this was not specified. • Six of the 21 individuals were listed as having no dining equipment, three of whom received only enteral nutrition. However, in the case of Individual #97, there was no section to indicate that he did not have assistive dining equipment though he was also NPO and received only enteral nutrition. All others had a section that listed dining equipment. • In 0 of 21 PNMPs reviewed (0%), strategies for medication administration were included. • In 0 of 22 PNMPs reviewed (0%), strategies for oral hygiene were included. • In 2 of 21 PNMPs reviewed (10%), individual dining positioning was very clearly addressed in the plan. Most merely indicated that the individual was to be upright during and after meals. • 21 of 21 PNMPs (100%) reviewed included a heading related to communication, though the information included was very limited and only nine of 21 (43%) plans addressed any strategies for staff to use to communicate with the individual though in most cases this included only the use of manual guidance with verbal communication. It appeared that the therapists had done an excellent job of standardizing the format of these plans and that, in most cases, the information was consistently noted in the plans reviewed with a few exceptions. On the other hand: • The plans did not provide sufficient instruction related to wheelchair and dining positioning. • Instructions related to medication administration and oral hygiene were noticeably absent. • The communication instructions focused primarily on ways staff could interact with the individual rather than how the individual expressed their wants, needs and preferences. **Standard: PNM plans were incorporated into individual's Personal Support Plans.**	

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		Information from discipline specific assessments was included in the assessment portion of the PSP, including OT/PT, Nutrition, Speech, Medical, and Nursing, among others. Findings and recommendations were generally listed there. In most of the PSPs reviewed, there was also a section under the General Discussion Record that addressed review of the PNMP and, in most cases, the elements of the PNMP were outlined, but did not reflect actual discussion by the PST regarding the effectiveness of these. In addition there was no evidence that these strategies were incorporated into other aspects of the PSP. In the cases of Individual #115, Individual #93, and Individual #71 (each were enterally nourished), there were no SPOs related to the therapeutic feedings provided to them under the direction of the SLP. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** Individuals who had received PNM supports were reviewed prior to the annual PSP meeting to complete assessments/updates and to address changes needed in the PNMP. These findings were documented in the OT/PT and SLP assessment reports. Other than attendance by a diet technician or food service monitor for eight of 21 PSPs, there was evidence of attendance by other PNMT members for the following individuals only: Individual #39 (SLP), Individual #116 (SLP), Individual #152 (SLP and OT), Individual #28 (SLP), Individual #15 (COTA and SLP), and Individual #103 (SLP). Oral hygiene, and medication administration were not addressed in the PNMPs. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** There was evidence in each of the OT/PT assessments that the PNMPs were reviewed and recommendations for changes were made at that time. In addition, most individuals had multiple updates throughout the year. The dining plan aspect of the PNMP was reviewed predominately with regard to the diet texture and liquid consistency. There did not appear to be an extensive and comprehensive review of the mealtime strategies and position. For example, in the case of Individual #74, the OT assessment dated 9/30/10 referenced an assessment by the SLP dated 5/12/08 at which time his diet texture was changed to ground food and nectar-thickened liquids. The OT merely listed the adaptive equipment and purpose, but did not report how effective they were. The focus of the PNMP was described to reduce the risk of penetration and aspiration, but there was no statement as to how well the plan was working for Individual #74. The SLP assessment went into significant detail regarding his swallowing history, citing silent aspiration and aspiration pneumonia in June 2010. He indicated that the diet texture was pureed with	

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		honey thickened liquids. Clearly, there was absolutely no collaboration or integration for the assessment provided for Individual #74. In the General Discussion Record of the PSP, there was generally a section that included a PNMP heading. In most cases, the elements of the PNMP were outlined there, but there was no statement that the plan was accurate or that it required changes. In the recommendations section of the assessment aspect of the PSP, there was typically a statement that the PNMP would continue to be monitored by the therapists. There was little evidence that there had been a discussion of the plan and certainly not related to the risk indicators identified for each individual.	
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.** PNMPs and Dining Plans were developed by the therapy clinicians and pictures were included for equipment and positions. Wheelchair positioning instructions were generally not specific in the PNMPs. 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, but not specified in the PNMPs. The photographs were very small and in many cases distorted. They did not offer sufficient support to the written information for staff to rely on as an effective resource. Actual detail with regard to alignment and support were lost in the pictures attached to the plans. The only point of service plan was the Dining Plan. The mealtime position pictures in the Dining Plans were larger and easier to identify proper alignment during meals. These pictures appeared to have been improved since the previous onsite review. The Dining Plans included photographs of the adaptive mealtime equipment, but there were no pictures pertaining to actual assistance techniques and strategies. Based on observations of individuals during meals across a variety of homes, there was also some improvement in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP, though there continued to be some concerns noted. Some examples are presented below: • Individual #4 was observed being assisted at dinner by a floater staff. He was coughing during presentation of fluids. These were poured into his mouth with his head hyper-extended and turned to the right. He was vocalizing, there were audible swallows, gurgling, and wet breath sounds. Staff reported that she had not received any training, but was told to read the Dining Plan. There were no instructions related to head position or pace and flow of presentation.	Noncompliance

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		• Individual #70 was to have jaw support during presentation of fluids. Staff were holding a towel under his chin to catch spillage, but was not offering actual support to his jaw when he was drinking. • Individual #126 was supposed to use a foot box during the meal per her Dining Plan. This was not available to her. • During the PST meeting for Individual #43 observed by the monitoring team, the individual's mother reported that she had observed staff not following her plan and giving her a full glass of liquids. • In home 513, there were four individuals seated at the dining tables at 11:30 am with beverages. A spouted cup of fluid was placed on the table for Individual #52, but was not offered to her. The food did not arrive in the home until 12:00 and then it took up to 30 additional minutes for some individuals to be served their meal. • Direct support staff was preparing an alternate beverage for Individual #52. The instructions for using the gel thickener said that staff should use two pumps for eight ounces of fluid for nectar thick fluids. Staff used three full pumps for less than eight ounces of Ensure, which is generally considered nectar-thick and would likely not need additional thickener. • Individual #90 was noted to cough during his meal. Staff reported that he coughed to get attention. He was eating lettuce with dressing that had not been mixed thoroughly and was too dry as a result. The PNMPC monitoring the meal did not identify this when he assessed the food texture. Later in the meal, he was served dry bread crumbs and dry meat. Though there was a small amount of gravy over the meat, it had not been thoroughly mixed and most of it was still dry. His plan indicated that dry foods should be moistened. Again, the PNMPC did not identify this problem and did not intervene. • Individual #52 was observed to drink three fourths of a full glass of liquid without stopping and with no staff intervention. • Individual #52 was observed to grab an open pitcher of thin liquid with ice sitting on her table. She quickly poured some in her glass. The monitoring team directed staff to intervene, but she quickly drank some of the thin liquid before it could be removed. The PNMPC present did not intervene or provide any assistance to staff. Staff did not remove the pitcher. This was the third time this monitoring team observed Individual #52 at mealtime across one full year of onsite reviews that she received liquids that were not consistent with her diet order. • Individual #65 grabbed the same pitcher described above and attempted to pour the thin liquid in his cup, though his Dining Plan instructed that only staff should pour his liquids. Staff intervened and finally moved the pitcher to another table. • Individual #68 waited over an hour before he was assisted to eat. He had been	

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		seated at the table at least 30 minutes before the food arrived in the home and then he was the last to be served. Staff stood on his right side, but reached across to present food to him using the comfort grip spoon designed for independent eating. His Dining Plan indicated that staff should provide hand-over-hand assistance. No one sat with him through the meal and the staff left him numerous times to assist others in the room. There were four staff for 11 individuals, one of whom was on 1:1 supervision. There was no one to consistently assist him or redirect the self-stimulatory behavior as directed on his Dining Plan. • Staff did not intervene effectively to prevent Individual #96 from overloading his spoon. He was also permitted to drink his milk from the carton, which he poured into his mouth. The spoon listed in his Dining Plan was very large and did not appear to be appropriate if taking large bites was an issue for him. The bread was chopped appropriately but was very dry with nothing to moisten it. The SLP present in the Dining Room did not intervene until the monitoring team prompted him by asking questions about the Dining Plan. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Dining plans were generally out on the tables during the meals. A few staff were able to verbalize the rationale for specific strategies they were using as directed in the PNMP and/or Dining Plan, however, many did not appear confident and, as described above, there were errors in implementation suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served.	
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.** Per the documentation submitted, mealtime and dysphagia portions of New Employee Orientation training included only a written test; there were no skills-based competencies required. The lifting and transfer sections continued to have skills-based competencies via a checklist that outlined specific elements of performance by staff who completed the training. There was a requirement for re-training every two years. **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.** By report, inservice training for direct support staff required verbal and/or return demonstration. The inservice sheets submitted included extensive documentation of assessment by the clinician with recommendations rather than actual elements of	Noncompliance

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		performance expected of staff. For example: • In the case of Individual #132, there was a paragraph related to follow-up to a choking event with recommendations. The recommendations included that his diet order was chopped with regular fluids. There was no evidence that staff were required to recognize chopped foods and make corrections if an error in preparation was noted. The text was in professional jargon and was not appropriate for staff use. The inservice sheet was dated 11/5/10 and staff signatures were dated 11/5/10, 11/6/10, and 11/8/10. There was no evidence that the clinician had actually conducted the inservice. • In the case of Individual #119, there was also a paragraph relating to the SLP's assessment during a meal with recommendations. The inservice sheet did not outline staff performance criteria related to assisting Individual #119 during her meal. Again the text was in professional jargon and inappropriate for staff use. The recommendations included a diet order of ground foods and verbal prompts in to eat Spanish, but that they no longer needed to load her spoon. These should be listed in lay terms and used to outline the inservice not to serve as documentation by the clinician. The staff inserviced were only required to verbally acknowledge these changes. There was no method to determine who had conducted the inservice as the sheet was dated 10/14/10 and staff signatures were on 10/18 and 10/19. Read and sign inservice training would not be considered to be competency-based. Further review of progress in this area will occur in subsequent onsite reviews by the monitoring team. **Standard: All foundational trainings are updated annually.** Lifting and transfer, mealtime, and communication training were updated annually after initial NEO training. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Initial staff training was conducted by Habilitation Therapies for available staff and PNMPCs. Cascade training was conducted by PNMPCs and, in some cases, the home managers. There was no mechanism to ensure that staff training occurred as outlined in the training plans when not conducted by Habilitation Therapies staff. Per the POI, PNM issues were not always trained and monitored by staff who were fully competent and further training was needed and ongoing. They anticipated completion of this training within 24 months.	

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		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 generally performance-based, and did not require successful performance of clearly established competencies. Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** The monitoring team observed a floater staff who was assigned to work with Individual #4 during an evening meal. She was observed to pour liquids into his mouth and he was noted to have audible swallows and gurgling with wet breath sounds. His head was held in significant head/neck hyperextension. This concern was communicated to the SLP and she initiated a re-assessment of Individual #4 and his Dining Plan during this onsite review. A number of possible strategies were attempted and were successful. Further assessment and extensive staff training were indicated and follow-up by the monitoring team will occur during the next onsite review.	
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. There were some very limited guidelines for PNMPCs related to how to fill out the forms. Use of the current monitoring tools were being reviewed and revised to increase their functionality and to ensure that monitors were implementing this process appropriately. Validation by clinical staff was scheduled though it was reported that this was not consistently done. There had been follow-up to address findings of the monitoring in a manner to provide additional training for the PNMPCs. This process was observed and should offer sound feedback to improve implementation of the current system. As described above the PNMPC observed to conduct a mealtime monitor did not identify several key issues during the meal and did not intervene appropriately. **Standard: Monitoring covers staff providing care in all aspects in which the person**	Noncompliance

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		is determined to be at an increased risk (all PNM activities). Monitoring was conducted to address mealtimes, as well as communication, specialized equipment use and condition, transfers, and positioning in the homes. Bathing equipment was monitored, but it was not clear that bathing was actually observed. No monitoring was completed related to medication administration or oral hygiene. 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 had been a significant number of monitoring sheets completed in the last three months, predominately by the PNMP coordinators, and a few by professional staff. The PNMPCs entered the data into a spreadsheet that could be used to track the actual frequency of monitoring conducted and to permit follow-up to issues identified. There was also a system of requested monitoring in addition to scheduled monitoring to permit follow-up to concerns or for newly implemented plans to ensure consistency. **Standard: All members of the PNM team conduct monitoring.** Evidence of formal monitoring by the clinical staff was limited to validation monitoring of the PNMPCs and technicians. The PNMT was only recently implemented and the primary method of monitoring was limited to follow-up meetings rather than actual observation by team members. The dietitians were available only a day or so a week and did not conduct monitoring beyond their nutritional assessments. There was no evidence that the RN team member conducted monitoring of the PNMP. PNMP monitoring addressed implementation of the plan only. There was no system of routine review (as determined based on risk or the acute nature of health concerns) by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. **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.** This system had only recently been implemented and follow-up occurred during PNMT meetings. It did not appear that they consistently used monitoring findings in their assessments to date. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** There was an expectation of immediate intervention when an individual was determined	

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		to be at risk of harm. Home supervisors or PNMPCs were not observed to intervene unless prompted to do so. The findings from PNMP monitoring were to be entered into the spreadsheet by the PNMPCs to permit follow-up by the clinicians when a concern was identified. Based on observations by the monitoring team, there were a number of issues identified throughout this report that suggested the PNMPCs were insufficiently trained to consistently identify concerns that required attention by the therapists.	
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.** The new health risk assessment process and the new PNMT process were only recently implemented and further review during the next onsite visit will be necessary to determine the effectiveness of these systems. **Standard: Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.** Individuals with PNMPs were reviewed on an annual basis with changes in the interim generally as indicated, loosely based on risk level. In the case that an individual participated in direct therapy, a monthly progress note was written though very few individuals received this. PNMP monitoring was completed by PNMPCs and, as such, these paraprofessionals would not be able to make judgments as to efficacy of the plans and to determine if there was a positive outcome related to PNM risks. Currently, there was no other system of monitoring of PNMP effectiveness for those at highest risk.	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 is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Standard: All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.** There were 16 individuals listed as receiving nutrition and hydration enterally. Individual #115 received oral pleasure feedings at the time of this onsite review. There was no integrated team approach to establish his return to oral intake and he experienced two episodes of aspiration pneumonia in less than six months as a result. He had to resume non-oral intake several times. Though the current Dining Plan outlined that direct support staff were to offer oral intake with monitoring by the SLP there was no documentation regarding this process in the integrated progress notes. There had been no written assessments or reviews by the SLP since 12/27/10.	Noncompliance

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		There was no evidence that there was a specific PST review of those who received enteral nutrition on an annual basis to address medical necessity. The PNMP committee reviewed these individuals annually, but the discussion was primarily a discussion of status rather than the continued medical necessity for enteral nutrition. The SLP appeared to conduct some level of assessment, but did so independently of other team members. The new risk assessment policy provided an assessment tool to address this and further review of this process will be conducted by the monitoring team in the future. **Standard: People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.** All individuals who received non-oral intake had been provided a PNMP that included the same elements described above. Based on a review of 21 PSPs in the individual record sample, there were four individuals who received enteral nutrition and nothing by mouth. These individual's PSPs did not document the rationale for the continued need for enteral nutrition. There also was no evidence that the PST reviewed the need for tube placement prior to or immediately after tube placement. In the case of Individual #115, there was no evidence that the PST met to discuss return to oral intake as recommended by the SLP, though he had experienced two episodes of aspiration pneumonia in less than six months. **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 was no protocol outlined for this process. In the case of Individual #115, in December 2010, the SLP determined that it was appropriate for Individual #115 to resume oral intake and sought an order from the PCP. He designed a plan and provided staff training with no input from other team members to ensure that this was safe and effective. After discussion with the monitoring team, it was determined that his case should be reviewed by the PNMT and this was done during the week of this onsite review. Per documentation, Individual #115 had PEG tube placement in February 2010 due to a decline in function with oral intake resumed on 2/25/10 after a swallowing evaluation by only the SLP. He was eating independently and subsequently was diagnosed with pneumonia. A follow-up swallow study showed no aspiration with carefully controlled bites and sips, however, due to a decreased level of alertness, the SLP recommended that he receive no oral intake at that time. On 4/26/10, the SLP recommended that he be assisted by staff to eat pureed foods and honey thickened liquids by mouth. There was no evidence of PST review. He again was diagnosed with aspiration pneumonia in June 2010. A PST meeting on 6/15/10 indicated that the SLP and OT/PT would complete assessments. The SLP again recommended nothing by mouth and oral intake of cold	

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		distilled water by speech staff only (Frazier Free Water Protocol). The PNMP was revised on 7/7/10. There were no further PSP addendums to reflect that the PST met to review the assessment findings. There was no documentation related to his status with regard to the Frazier Free Water Protocol, though the nutrition assessment dated 10/8/10 reported that it was in use at that time. On 12/27/10, the SLP again recommended that Individual #115 return to oral intake and outlined instructions for direct care staff. The SLP indicated that staff would be trained with monitoring by RTT-3s, RTT-4s, PNMPCs, or the SLP for at least one meal daily to track for 100% compliance with the plan and no significant coughing during the meal. At that time, monitoring would change to monthly. No collaboration with other team members occurred. The Dining Plan was written with excessive technical jargon and did not carefully outline all necessary assistance strategies to ensure that staff implemented the plan safely and effectively including bite or sip size and position/alignment. It was of grave concern that this clinician proceeded again with oral intake without full collaboration with other team members to assess and design a support plan as well as staff training and monitoring to ensure that all aspects of his PNMP were appropriate to support oral intake. Given the individual's history of aspiration pneumonia, numerous variables needed to be considered prior to resuming oral intake, including positioning for oral hygiene, medication administration, bathing, oral and non-oral intake, to adjust non-oral intake as indicated relative to oral intake, and other aspects of his care. The entire PST should have been involved in this decision as well as in the design and implementation of the plan. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** One aspect of the new At Risk Individuals policy implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times or within the last year as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nursing case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST. This assessment had not been completed at the time of this review so further assessment will be necessary by the monitoring team in the future. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** 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, and	

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		positioning and assistance techniques to ensure safe eating and drinking. However, as described above, it appeared that diet texture modifications were made in an almost knee-jerk reaction rather than the provision of a comprehensive assessment at mealtime to determine if there were other less restrictive strategies that would be effective (Individual #73 and Individual #13, for example). Often these appeared to be made because staff had not followed mealtime instructions rather than as a function of what was most appropriate for the individual.	

Recommendations:

1. Continue to refine the development of specific staff training competencies in the area of PNM. The existing new employee orientation training should be reviewed to ensure that it focuses on skills and not only on didactic presentation of clinical information. Competency must be predominately skills-based. When a written or verbal response is indicated, ensure that the information is critical to staff implementation and that there is no alternate means to test understanding.

2. Develop a policy or at least more comprehensive written guidelines related to the monitoring system.

3. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency. Include a mechanism to document recommendations for follow-up and a means to document closure on issues identified. This often works well when this is included on the form used to monitor. The elements tracked in the spreadsheet need to be simplified to ensure effective review and analysis.

4. The focus of competency-based training for the PNMPCs should be on skill performance relative to monitoring and training, rather than only clinical knowledge. Ensure that re-validation of monitors occurs on a regular basis to ensure consistency and accuracy. It must be emphasized that the PNMPCs are expected to intervene and coach staff. An approach of working side-by-side with direct support staff sets a more collaborative role, rather than standing back and completing the monitoring form as observed by the monitoring team during this review.

5. Conduct trend analysis of all monitoring data. Review findings and make system adjustments. While it is important that the clinicians review findings from the validation monitors with the PNMPCs, it is critical to establish a mechanism to review the overall trends and findings to drive staff training in the homes and other settings in which the PNMP is implemented. This review is an important quality improvement element.

6. PNMT assessment and review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, "Mary will be pneumonia free for six months." Interventions should support achievement of identified outcomes. The PNMT should continue to monitor until the individual attains and maintains at the goal level. This may become more easily integrated with the new process. Assessments should be new evaluations of the individuals referred that are collaborative and integrated with all PNMT members, not merely a review of previous discipline-specific assessments. This will be more difficult as the same staff clinicians also serve as the experts on the PNMT. It will be critical to view these individuals in a new manner in order to yield new information and new intervention plans for individuals who have been referred.

7. Identify OT and RN members of the PNMT.

8. There was a need for a well outlined agenda to keep the PNMT meetings on track and moving along.

9. Carefully consider who should be referred to the PNMT at this time. During this interval of change relative to the new health risk assessment process and the new PNMT process, it will be critical that those who require PNMT assessment are identified and receive it in a timely manner.

10. Consider a significant increase in nutritional staff. Two very part-time dietitians and a diet technician are insufficient to adequately meet the needs of all individuals with PNM concerns.

11. Integrate instructions for staff related to medication administration and oral hygiene in the PNMP.

12. Review individuals with diet order changes secondary to swallowing-related concerns over the last two years. In some cases, problems were reported to be related to staff compliance with dining plans, yet the individual's diet order was changed or other restrictive measures were taken. The plan should be designed for the individual, then staff training and careful monitoring must take place to ensure competent and consistent implementation.

13. Review photographs in PNMPs and Dining Plans to address size and clarity of detail for staff reference.

14. Continue careful comprehensive and well integrated assessment of Individual #4 to design appropriate mealtime supports. The assessment initiated during this review was an excellent start and he responded very well to slow, but purposeful changes introduced by the SLP during one meal. It is important to conduct careful trials of alternate strategies rather than merely accept the status quo assuming that an individual with challenging mealtime behaviors cannot change. It is critical that these steps involve the entire team in order to consider each variable to ensure safety and to minimize risks.

15. This activities described immediately above are also critical for Individual #115 as well. There may be other individuals for whom a re-assessment of mealtime strategies would also be indicated.

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 Clinical Staff list CVs for Eric Herrera, PT, Susan Acosta , PT, DPT o State License verification for clinical staff o Continuing Education documentation for clinical staff o OT/PT Policy #14 o EPSSLC POI o Presentation Books for Sections O, P, and R o HST meeting minutes o HST Risk Assessment risk lists o Hospital Leaves 1/1/09 and 12/3/10 o Emergency Room visits o PT Database o List of adaptive mealtime equipment o Dining Plan training sheets submitted o NEO Training modules with checklists and competency tests o Dining Plans submitted o Dining Plan template o Guidelines for PNMP monitoring and Mealtime Observations o List of individuals monitored in October and November 2010 o Requested or Observed Monitoring Form o PNMP Monitoring Form o Mealtime Monitoring Form o Mealtime Observation Sheet o Completed monitoring sheets submitted o List of individuals with PNM needs o Completed Requested or Observed Monitoring forms submitted o OT/PT Referral Source spreadsheet o OT Assistive Equipment List o RTT3 Facilitator Form o Mat Assessment template o Work Order spreadsheet o List of individuals on modified diets/thickened liquids o Food Texture/Liquid Consistency Downgrades o List of Fall Incidents 8/1/10 to 10/31/10 o Injuries Fracture-Suture-Dermabond 10/1/09 – 10/31/10 o Weights with BMI >30

- Weights with BMI <20
- Individuals with unplanned weight loss of 10% or greater in last six months
- List of individuals with enteral nutrition
- Decubiti spreadsheet
- Choking Incidents 12/6/08 – 11/23/10
- List of individuals with poor oral hygiene 1/22/10
- List of Individuals with Wheelchair as Primary Mobility
- List of Individuals with Wheelchair for Transport
- List of individuals with Gait Belts or Gait Trainers
- List of individuals with Orthotics
- Preventative Maintenance spreadsheet
- PNMPs submitted
- List of individuals with Dysphagia
- List of individuals with Pneumonia
- List of individuals receiving Direct PT
- Documentation for individuals who participated in direct PT:
  - Individual #9, Individual #84, Individual #90, Individual #78, Individual #74, and Individual #5
- OT/PT Assessments and PNMPs/Addendums for the following:
  - Individual #144, Individual #35, Individual #23, Individual #83, Individual #114, Individual #110, Individual #125, Individual #18, Individual #20, Individual #55, Individual #27, Individual #58, Individual #46, and Individual #93.
- Personal Records for sample of individuals including: Comprehensive Nursing Assessments, Nursing Quarterlies, current list of medications, PNMPs for last 12 months, Dining Plans for last 12 months, contents Habilitation Therapy tab, Annual Nutrition Assessments and quarterlies, PSP and addendums, PSP quarterly reviews, Incident/Injury reports for fractures, choking or swallowing events, hospitalizations records, MBSS reports and follow-up by SLP, contents Gastroenterology tab, contents Orthopedics tab, Integrated Progress Notes from 1/1/10 to 1/4/11 and, monitoring sheets completed for last six months as submitted for:
  - Individual #39, Individual #84, Individual #97, Individual #115, Individual #15, Individual #116, Individual #178, Individual #103, Individual #119, Individual #123, Individual #152, Individual #78, Individual #33, Individual #113, Individual #28, Individual #74, Individual #4, Individual #13, Individual #132, Individual #12, and Individual #73

Interviews and Meetings Held:

- Anderson Hicks, OTR, Director of Habilitation Therapies
- Susan Acosta, PT, DPT
- Eric Herrera, PT
- Jessica Cordova, PT
- Sandra Moreno, PTA
- Dahlia Castillo, OTR
- Clara Aguilera, COTA

	o Alfredo Diaz De Leon, COTA o Various Supervisors and Direct Support Staff o Meeting with OTs and PTs o PNMT meetings for Individual #84 and Individual #115 o PST meeting for Individual #43 Observations Conducted: o Living areas o Dining rooms o Day Programs o Habilitation Therapies clinic areas
	Facility Self-Assessment: EPSSLC's self-assessment identified noncompliance for all items of this provision. This self-assessment was consistent with the monitoring team's assessment of noncompliance.
	Summary of Monitor's Assessment: Since the last review, the focus for OT/PT had been related to a focus on measurable outcomes and the provision of staff training. The assessment format was revised to include potential for skill acquisition and to attempt to integrate risk issues into the assessment. Too often, however, deficits were viewed as barriers to skill acquisition rather than as opportunities for intervention and training. There continued to be insufficient comparative analysis related to progress or regression from the previous assessment. While clinicians appeared to promptly address issue-specific or problem-oriented concerns for individuals, the documentation was in a separate assessment and not in the Integrated Progress Notes for ready access by other team members. In addition, the very few interventions provided by therapies were not integrated into the PST process itself. In general, however, it appeared that staff were attending better to the details of proper positioning and compliance with the PNMPs and implementation was improved since the previous onsite review by the monitoring team. The PNMPCs, however, were not consistently observed to identify and intervene as issues came up related to direct support staff implementation of the PNMP. The PTs took leadership roles in many aspects of the department and appeared to have strong clinical skills. The OT staffing continued to be a significant concern. The single OT employed previously had resigned and there was a very part-time OT and a new graduate along with the two COTAs. It is imperative that staffing in this area be increased and that there is sufficient support to ensure that the newly graduated OT is successful in this environment. The clinical staff appeared to work well together and presented with a strong knowledge base relative to therapy clinical information. There was a need to tighten up their systems and documentation.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Standard: The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.** The Habilitation Therapies Director was Anderson Hicks, OTR. As of 11/30/10, the only other OTR resigned and, at the time of this review, there was one part-time OT (Dahlia Castillo) contracted to work one day a week and possibly on weekends (six to 10 hours per week). In addition, a full time OTR, who was a new graduate, had been hired and was in New Employee Orientation during the week of this onsite review. There were two OT assistants (Clara Aguilera, COTA, and Alfredo Diaz De Leon, COTA), though each provided more limited services due to supervision requirements. There were three OT technicians (2.5 FTEs). PT services were provided by two full time therapists: Susan Acosta Conradi, PT, DPT, and Jessica Cordova, PT, and one part-time, Eric Herrera, PT. There were was one PT assistant, Sandra Moreno, PTA, and three PT technicians (2.5 FTEs). There was one health and wellness technician who implemented programs developed by the therapists, such as walking programs. Evidence of current licenses was submitted for each of the licensed clinician except the newly hired OT and the part-time contract OT. Ms. Castillo's license was current as verified online, but it was not possible to verify the new graduate's license. CVs were not submitted for any staff so it was also not possible to verify their experience or other specialized training. There were four Physical Nutritional Management Plan Coordinators (PNMPCs); one worked in the evening and the other three worked days. At least one of these worked half time as a speech technician and was currently out on medical leave. A fifth position had been posted and, when filled, will be an evening position. Each PNMPC also worked across weekends in rotation. OT staffing levels would be considered to be the same as during the previous review upon the new hire's completion of NEO. PT staffing levels remained essentially the same. Fabrication of seating systems occurred onsite, though the primary fabricator had resigned since the previous review and had not been replaced. There were only two full-time technicians working in this department. The fabrication department was responsible for collaborating with therapy clinicians to design seating systems for individuals living at EPSSLC, fabricating custom components, and completing repairs and modifications. There was no documentation submitted as evidence of training, experience, or qualifications for the fabrication staff. Per the Preventative Maintenance spreadsheet submitted, quarterly maintenance had been not been provided routinely for every individual who had a wheelchair. There was no tracking related to routine	Noncompliance

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		maintenance for other equipment. In addition, the work order spreadsheet showed that work orders as far back as June 2010 were incomplete as of October 2010. It appeared that nearly 100 work orders had not been addressed at that time. Evidence of participation in continuing education for therapy clinicians was submitted as follows: NMT/PNMP/Equipment Webinars (DADS): • Jessica Cordova, PT (8/13, 9/1, 10/27/10) • Clara Aguilera, COTA (7/30, 9/1, 10/27/10) • Alfredo Diaz DeLeon (9/1/10) • Susan Acosta, PT, DPT (7/30, 10/27/10) Contact hours were not consistently recorded for these sessions, but generally ranged from one to two and a half hours each. Therapy technicians had also attended these on some dates. There was no other evidence of continuing education for the therapy clinicians submitted. The current census reported at the time of this review was 134 individuals at EPSSLC. Based on a list submitted, 100% of the individuals presented identified PNM needs. During discussion, however, it was determined that this list represented every individual who had a PNMP. Essentially this plan was provided to every individual at EPSSLC, including those with only eyeglasses, even though they may not have had any other physical/nutritional management needs. Based on review of the records submitted, there were at least 26 out of 35 (75%) individuals with identified needs related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. One individual had received direct OT/PT services (Individual #78) and only five had received direct PT services and included Individual #5, Individual #90, Individual #9, Individual #74 and Individual #84. An intervention plan for Individual #78 had to be discontinued on 11/23/10 because there was no OTR to supervise implementation of this plan. Only Individual #5 and Individual #9 continued with PT at the time of this onsite review. Others received indirect services via the PNMP and the provision of assistive equipment and/or orthotics. **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** OT/PT assessments were completed as a more discrete measure of status rather than screenings for all individuals. This was a combined OT/PT Comprehensive Assessment.	

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		Only two individuals were listed as admitted since the previous review and included Individual #191 and Individual #144. By report, all assessments were completed within 30 days of admission. According to Anderson Hicks, Habilitation Therapies Director, Individual #191 had not actually been admitted and, as such, had not been evaluated by OT or PT. The assessment for Individual #144 was submitted as part of the department's presentation book materials for the monitoring team, and it had been completed the day following his admission, well within the 30-day timeframe. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30-day period, by report. There was no system to track specific referrals generated by the PST or via PNMP monitoring through to resolution. Based on the sample reviewed, 34 out of 35 (98%) of individuals had a current OT/PT assessment (Individual #73's assessment was incomplete as submitted and as such the date was not identified). Additional discipline-specific assessments were completed on a referral or consult basis for specific issues. These were generally completed well within the 30-day timeframe and most often in only a few days after referral. The rationale for an extended time period was clearly documented. Some examples included: • Individual #178: Doctor's referral on 10/26/10 related to discomfort sleeping in bed. PT consultation completed on 10/28/10 and 11/2/10. • Individual #97: PNMT referral on 11/12/10 related to need for clarification of positioning schedule. PT consultation completed on 11/22/10. • Individual #113: Referral on 11/17/10 for assessment for lap tray. This was completed on 12/22/10 due to hospitalization in November and December. • Individual #74: MD referral on 10/26/10 for PT assessment for ambulation outside and to workshop. This was completed on 11/4/10 with documentation on 11/8/10. In most cases, documentation of actions taken were well documented by the clinicians, though were written in separate OT or PT Assessment documents filed in the individual's records under the Habilitation Therapies section rather than in the integrated progress notes. **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.** All individuals received an OT/PT assessment on an annual basis even if they had not	

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		required supports or services during the previous year. These were identified as either an OT/PT Comprehensive Assessment (23) or OT/PT Assessment Update (10). The Updates had each been completed prior to the previous review and since that time the title of the document had been standardized as an Assessment. The department had conducted internal audits and training to address this issue successfully. Of the assessments reviewed, 34 out of 35 (95%) had been completed prior to the PSP staffing date, though it was not clear that the assessment report was available to the PST prior to the annual meeting. In a number of cases, there was a separate OT or PT Assessment for a change in status, most often related to a hospitalization and per referral or request by the physician, PST, or NMT/PNMT. These were generally brief notes in SOAP format, were not usually comprehensive but rather addressed specific concerns. Some examples included: • Individual #115: PT Assessment on 10/26/10 post move to a new home, from 515 to 507. • Individual #113: PT Assessment on 12/17/10 following discharge from the hospital on 12/16/10 with a diagnosis of UTI and blood infection. The PT Assessment was thorough and comprehensive. The note documented that the PT worked with Individual #113 on three occasions that day and observed his positioning, transfers, circulation, sensation, vitals, and skin integrity. The OT Assessment on the same date was noted though documentation was less comprehensive in scope. The most recent OT/PT Comprehensive Assessment included the following sub-headings: Pre-Assessment Meeting: I. General Information • Abbreviations/terms • Active Problems • Medications • Past Medical History/Background Medical Summary • Identified PNMP Risks, Analysis and Rationale for Interventions • Communication II. Behavioral Considerations III. Assistive Equipment IV. Assistive Dining Equipment V. Functional Assessments • OT Intervention • BUE ROM, Strength and Muscle Tone • Head and Neck	

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		• ADL Function and Potential for Skill Acquisition • Eating Ability/Nutritional Management and Potential for Skill Acquisition • Reflexes/Reactions • Sensorimotor/Fine Motor Functional and Potential for Skill Acquisition VI. Motor Functional Evaluation • Wheelchair and Potential for Skill Acquisition • Strength • Skin Integrity • Braden Scale Score • Posture • Transfers and Potential for Skill Acquisition • Balance • Fall Risk Assessment • Gait • PT Intervention VII. Integrated OT/PT Collaborative Summary • Likes/Dislikes • Functional Abilities VIII. VIII. Physical and Nutritional Management Plan • Focus • Review • Nutritional Management • Hospitalizations • Emesis • URI • GI/EGD • Weight • Lab • Diet IX. Recommendations X. Integrated OT/PT Summary of Community Living Options Each of the assessments reviewed contained the same headings and, as such, addressed movement, mobility, range of motion, independence, and functional status. The clinicians documented functional examples of systems level findings, such as range of motion, strength, and muscle tone more consistently. For example: • Individual #12 was described with active upper extremity range of motion	

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		within functional limits as observed by her raising both arms overhead to remove her helmet and place it on the floor next to her. Activities of daily living skills, such as dressing, bathing, oral hygiene, and toileting were dependent primarily on direct support staff reports. Observation of these activities was not consistently documented. This limited the clinician's ability to identify potential for skill acquisition and therapy consultation for program development in these areas. Observations during mealtimes, however, were generally conducted. Observation of fine motor skills was limited in a number of cases and interventions or programs to address deficits in this area were not noted in any case reviewed. For example: • Fine motor skills for Individual #18 were during ADLs and mealtime only, rather than day program and work settings. He was described with fine motor skills within functional limits, though he had refused to engage in other fine motor tasks. The clinician stated that he exhibited uncooperative and SIB behaviors that interfered with his potential for skill acquisition. There were no specific recommendations to address this concern other than to redirect him when he engaged in SIB. • In the case of Individual #20, the ADL portion of her assessment dated 9/10/09, stated that she required total assistance for dressing. There was no detail to describe any level of participation she may have demonstrated, such as pushing her arms through the sleeves or holding out her foot for shoes or socks. These kinds of details provide vital information as a foundation for skill acquisition potential, but this was described as poor for Individual #20 because she had a short attention span and lack of focus. There were no recommendations for interventions or programming to address these concerns or her dependence in ADL. The monitoring team requested that the five most current assessments completed by each therapist with the associated PSPs be submitted. OT/PT Comprehensive Assessments were submitted for the following individuals: • Individual #18 (PT: 10/11/10; OT: 10/24/10) • Individual #83 (PT: 9/27/10; OT; 10/1/10) • Individual #110 (PT: 10/12/10; OT: 10/24/10) • Individual #93 (9/18/10) • Individual #46 (9/17/10) • Individual #125 (PT: 10/5/10; OT: 10/25/10) • Individual #114 (PT: 10/7/10; OT: 10/25/10) • Individual #58 (9/13/10) • Individual #27 (8/24/10 – 8/27/10)	

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		• Individual #23 (9/28/10 – 9/29/10) • Individual #35 (9/23/10 – 9/26/10) • Individual #55 (9/21/10 – 9/26/10) • Individual #20 (PT: 9/28/10; OT: 9/10/09, this date was likely a typographical error) PSPs for these individuals were also requested. While a current PSP in the department file would be most appropriate, those files would not be the primary concern of the monitoring team, but rather the active record for each individual. It is of utmost importance that the current PSP be maintained in this active record. It was unclear if these PSPs were from the active record or from the departmental file. At any rate, 11 out of 13 (85%) of the PSPs submitted were marked as drafts rather than final copies. Each annual meeting had been held on 10/25/10 or earlier, certainly ample time for the PSP document to have been finalized. Three of the meetings had been held in November 2010 and, as such, may not have been in the final form at the time the document request was submitted. An Occupational Therapy/Physical Therapy Initial Evaluation was submitted for: • Individual #144 (8/5/10) Personal records were also requested for a sample of 21 individuals and assessments were submitted as follows for: OT/PT Comprehensive Assessment • Individual #78 (8/19/10) • Individual #97 (7/30/10) • Individual #103 (10/12/10 and 11/12/10) • Individual #4 (PT: 6/18/10; OT: 6/25/10) • Individual #33 (9/14/10 – 9/23/10) • Individual #116 (3/16/10 – 3/17/10) • Individual #132 (PT: 11/4/10; OT: 12/29/10) • Individual #152 (1/21/10) • Individual #74 (PT: 8/28/10; OT: 9/30/10) OT/PT Assessment Update • Individual #28 (4/13/10) • Individual #115 (5/4/10 and 5/25/10) • Individual #113 (4/16/10) • Individual #84 (1/18/10 and 1/20/10) • Individual #178 (2/16/10 and 2/27/10)	

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		• Individual #12 (PT: 1/11/10; OT: 1/28/10) • Individual #123(PT: 4/15/10; OT: 4/21/10) • Individual #39 (4/21 and 4/28/10) • Individual #13 (2/28 and 3/1/10) • Individual #15 (6/7/10 to 6/15/10) • Individual #119 (5/25/10 and 5/30/10) • Individual #73 (copy incomplete as submitted) Current annual PSPs were submitted for 30 out of 32 individuals, with addendums also submitted in most cases as present in the personal records. No annual PSP was submitted for Individual #178 and the PSP for Individual #103 was dated 12/1/09 and was incomplete. Documentation for those who received direct PT (no one received OT services at the time of this review) was requested by the monitoring team. Information submitted did not include the annual OT/PT assessments. Approximately 75% or 26 out of 35 assessments reviewed described individuals with significant movement disorders and limitations in self-care and/or functional skills. There were also approximately: • 135 (100%) individuals identified with PNM needs per the list submitted. • 57 (43%) individuals identified as non-ambulatory or requiring assistance for ambulation • 39 (30%) individuals who used a wheelchair as a primary means of mobility • 18 (14%) individuals who used assistive equipment for ambulation. • 34 (26%) individuals who used transport wheelchairs as needed • 37 (28%) individuals with upper or lower extremity orthotics, braces and/or orthopedic shoes. • Ten individuals who sustained an injury requiring sutures or dermabond or resulting in a fracture (three) due to a slip, trip or fall • Seven individuals who had experienced three or more falls from 8/1/10 to 10/31/10 • Seven individuals considered at risk of skin integrity issues; 13 individuals with or more incidence of pressure ulcers/skin breakdown in the last year • Twenty-two individuals considered at risk of osteoporosis or osteopenia It was noted that only one individual had received direct OT/PT services (Individual #78) and only five had received direct PT services, including Individual #5, Individual #90, Individual #9, Individual #74, and Individual #84. Only Individual #5 and Individual #9 continued with PT at the time of this onsite review. Each of the PT	

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		interventions related to ambulation/gait training and the OT/PT intervention. Individual #78's program was for hand washing, assisted standing, and participation in mealtime setup to hand out cups at mealtime. Rationale for discontinuing these was identified as achievement of goals. In most cases, carry over was identified outside of skilled therapy. Justification for why other individuals would not require some level of intervention beyond the PNMP, particularly to address skill acquisition, was weak in most cases. Many received only indirect supports via annual assessments, PNMPs, or dining plans. In general, an initial comprehensive evaluation was completed for each individual upon admission and annual OT/PT Comprehensive Assessments for each individual. While the assessments were improved from the previous review there continued to be some issues related to these. For example, there was very limited evidence of a comparative analysis of health and functional status from the previous year. There had been the addition of a section to address potential for skill acquisition across a variety of areas including eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait and positioning. However, the consistent analysis of this focused on the rationale why there was no potential for skill acquisition. • The OT sited lack of attention, distractibility or that the individual lacked fine motor coordination which limited their potential for skill acquisition (Individual #161, for example). The clinician did not attempt to identify areas that could be improved such as greater participation for this individual who had functional hand skills for eating yet required total assistance for activities of daily living such as dressing and tooth brushing. • In the case of Individual #114, he was identified with poor potential for skill acquisition due to decreased focus, attention span, increased muscle tone and decreased fine motor coordination. He, however, demonstrated various grasp patterns, reaching overhead, and transferring objects and, yet, was reported to require total assistance for dressing, tooth brushing, eating, and hand washing. There was no finding to address these issues through interventions or programs. Though limited, there were more cases of findings for skill acquisition by the PT clinicians as documented in the assessment reports. Another area of concern relating to the assessments was that the current format tended to present the rationale and recommendations throughout the report rather than presenting the objective data, then using all the information to formulate the integrated clinical analysis and rationale for recommended interventions and supports at the end. For example, there was a specific section related to "PNMP Risks, Analysis and Rationale for Interventions." There was discussion of the PNMP and various supports in this section at the beginning of the report and then again throughout the assessment and also at the end of the assessment after the "Integrated OT/PT Collaborative Summary." There	

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		was duplication of information and the PNM information at the end was addressed separately and after the functional skills analysis. These should be considered in a more integrated manner and the analysis of findings in all these clinical areas should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations. The content was adequate, but if the format was reorganized, there would be less time required of the clinicians due to repetition or duplication and the analysis would be more likely to yield meaningful and functional recommendations for interventions and programs. Both a new PSP process and Health Risk Assessment process were in development and would likely further impact the OT/PT assessments over the next year. These clinicians should be highly commended for their ongoing self-examination and obvious efforts to improve the supports and services they provided to the individuals living at EPSSLC. **Per the Health Care Guidelines, the comprehensive assessment should address the following:** • **Movement;** • **Mobility;** • **Range of motion;** • **Independence; and** • **Functional Status across each of these areas (Health Care Guidelines, VIII.B.2)** Range of motion was generally addressed, though specific range of motion measurements were not provided. The clinicians had improved their descriptions of the individuals' functional range of movement, however, and this was a noted improvement. Overall, posture in a variety of positions was consistently described. Movement skills were included and, to some degree, the level of independence. However, descriptions were often limited to requiring "total" or "moderate" assistance rather than specifics that would offer more useful information to the clinicians and other team members, such as day program staff, for training or active treatment purposes. **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.** Discipline-specific and issue-specific assessments were consistently noted for a number of the individuals reviewed. Documentation, however, was separate from the integrated progress note section and, as a result, was not functional for utilizing this information to track and trend status in a holistic manner, but rather was separate, making it difficult for other staff to use the OT/PT findings. These were generally completed in a timely	

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		manner upon referral. **Standard: Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment.** The assessments consistently described the seating system components, with justification and a statement that it was or was not meeting the individual's needs. In most cases, these individuals were seen multiple times throughout the year and issues related to their seating were addressed in PNMP clinic and documented in clinic review notes. Recommendations for additional assessment were occasionally noted in the assessments submitted for review. For example, Individual #114 was reported to use his upper extremities to propel his wheelchair around furniture and others. It was determined that he might benefit from greater opportunities to do this within his home and outside. The FEET (Fun Exploring Environments through Training) program was a consideration and it was recommended that PT conduct further assessment to determine if he would benefit from participation in this program. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** There was generally a review of health and medical status included in various sections throughout the OT/PT assessment reports as well as a specific section intended to address PNM health risk issues and the indicated supports. Efforts to identify the rationale for these supports were noted, though as described above, there was some duplication and the format did not lend itself to comprehensive analysis of findings that included both health and medical concerns with functional skill abilities and potentials into an integrated therapy intervention plan and to provide a foundation for non-clinical supports and programs. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The clinicians discussed a plan for the annual assessment for each individual prior to initiating review to determine if it was critical to function together to gather objective data due to complexity of need or health/medical concerns. When this was deemed necessary, OTs, PTs and in some cases, the SLPs conducted aspects of the assessments and observation at the same time to promote further discussion and problem-solving at that time. Otherwise, the OTs and PTs conducted separate assessments and entered the	

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		data, findings and recommendations separately into a single report.	
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.	**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.** Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and was updated due to a change in status. All of the plans submitted were current within the previous 12 months and many had been updated since the PSP. Changes were identified by a symbol on the plan to alert staff to a change from the previous version. **Standard: Within 30 days of development of the plan, it was implemented.** As there were very limited intervention plans developed beyond the PNMPs, this element was not in compliance. Generally, however, when an action was identified as necessary to address a more acute issue, these actions were taken well within the 30 day period. These did not typically involve a PSP addendum, though documentation by the clinicians was consistent in most cases. A program change form was submitted but did not necessarily result in an addendum to the PSP with quarterly reviews by the QMRP. For example: • There was a PT SPO dated to begin on 11/11/10 for Individual #84. There was no addendum related to this and the PSP Quarterly Review for September 2010, October 2010, and November 2010 did not report on this SPO. A Progress Summary was written by the PT for interventions provided from 11/10/10 to 11/22/10. • Another SPO for Individual #74 was written by PT for implementation on 8/5/10. There were daily progress notes that indicated that this SPO would continue to address gait and transfers through 12/1/10. A program change form was completed by the PT on 12/7/10 to recommend discontinuing it as of 12/6/10. There were no PSP addendums or quarterly reviews submitted with evidence that this had been integrated into his PSP. • There was an SPO by PT/OT dated 9/13/10 for Individual #78 with implementation through 11/12/10. There was no evidence of integration in her PSP via addendum nor was this referenced in the quarterly review submitted. **Standard: Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.** One individual had received direct OT/PT services (Individual #78) and only five had received direct PT services, including Individual #5, Individual #90, Individual #9,	Noncompliance

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		Individual #74, and Individual #84. Only Individual #5 and Individual #9 continued with PT at the time of this onsite review. Others received indirect services via the PNMP and the provision of assistive equipment and/or orthotics. Functional and measurable goals/objectives were identified related to skill acquisition with each of the interventions. They were all written in a manner, however, such that the described skill was only required to be demonstrated one time for achievement. There were no other criteria to establish the frequency or consistency of performance expected. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs provided. PNMPs addressed areas related to positioning, transfers, range of motion, and mobility, but interventions were limited related to promoting independence and skill acquisition. PT interventions were limited to the five individuals identified and the one OT/PT intervention to address these areas. PT treatment was designed to address gait, ambulation and transfers. The OT/PT intervention was designed to promote hand washing, assisted standing and participation in mealtime setup. Those plans that were implemented were appropriate and generally well documented, however, the scope of service was limited to a handful of individuals only. As described above, the rationale identified to justify not providing interventions to promote functional skill acquisition or to enhance levels of participation or independence in activities of daily living was generally weak. Potential for change was deemed poor due to functional limitations that could have been the focus of direct or indirect therapy interventions as well as other programming in day programs or work settings. PNMPs included staff instructions or precautions in the areas of mobility, transfers, movement techniques, and positioning for wheelchairs, alternate positioning, bathing and bed. There were no supports outlined related to medication administration or oral hygiene. There were mealtime instructions and adaptive mealtime equipment was listed consistently. There was a very brief communication section with some listing the newly identified "Strategies for Optimal Communication" discussed in section R below. A list of assistive equipment was consistently provided in the plan. **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.**	

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		Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The assessments generally provided a brief rationale for the equipment recommended for use. The monitoring team noted that the pictures provided to support the plans and to serve as visual cues for staff were generally very small and often distorted. These factors greatly impact the usefulness to staff to be able to replicate details of the plan with accuracy. This was also noted in a number of cases for positioning and for splints provided. Clinical staff should consider using larger photos with multiple views and to continue to be very particular about the quality of the photographs to ensure adequate detail. When adjusting the size of photographs, they should be changed from the corners, not the sides to avoid distortion. A few examples included Individual #4, Individual #46, Individual #97, Individual #21 and Individual #183. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were minimal intervention plans, though these were generally well documented. Measureable goals were identified with documentation to quantify progress or regression. The rationale to not provide services to more individuals was generally weak, however, with suggestions that attention span, distractibility, and poor fine motor coordination, for example, were obstacles to functional skill acquisition, rather than skills to address through planned interventions. **Standard: On at least a monthly basis or more often as needed, the individual's 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.** In the case that an individual received direct therapy, daily progress notes were written and summaries were written monthly. Routine reviews of the PNMP was conducted on an as needed basis upon referral or based on the findings of scheduled or requested monitoring. There were no other monthly or quarterly reviews of these plans conducted by the licensed clinicians.	
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	**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 or per generally accepted practice. In some cases, the daily agenda in the individual books and the instructions on the PNMP did not match. A few individuals were observed sitting with a posterior tilt, loose seatbelt, or pelvis not well back into the seat of their wheelchair.	Noncompliance

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	implementing such plans.	Some additional examples included the following: • Individual #93 was observed with her head under the headrest. When staff noticed the monitoring team looking at her, they came in to realign her head. Staff did check and reported that it had only been 10 minutes since she had been eating and that they had to wait before repositioning her. • Individual #2 was observed in a recliner with her pelvis in severe posterior tilt, her legs were extended, and her back was very rounded. Her head was flexed forward on her chest. Her bilateral sheepskin palm protectors were not properly applied into the palms, but up under her fingers only. • Individual #107 was seated in a wheelchair. His trunk and head were tilted laterally to the left and his pelvis was asymmetrical and out or alignment. • Individual #58 was observed without footrests under her feet while seated in a wheelchair. Her PNMP stated that the footrests were to be in the wheelchair bag on the back of her chair. There was no bag and no footrests. When staff were asked they stated that they did not know why the footrests were supposed to be in the bag. They stated that when they were on the wheelchair, interfered with her moving her wheelchair. The monitoring team noted that the seat was elevated so that her feet barely touched the floor and, as such. would have been difficult to use her feet for propelling the chair. She was observed, however, using her hands to propel the chair down the hall. The direct support staff were not able to locate the footrests. There was no documentation by staff that her footrests were missing. • Individual #4 was observed being assisted to eat with his head and neck in significant hyperextension and turned to the right. He was noted with audible effortful swallows of liquids poured into his mouth by a “floater” direct support staff with coughing and significantly wet breath sounds and gurgling. The floater stated that she had not received training other than to “read the plan.” There were no instructions in his dining plan to address his alignment. • Individual #126 did not have a foot box under her feet during the meal as outlined in her dining plan and PNMP. • Individual #70 was observed in an assistive ambulation device. He was hanging with his armpits and neck against the tray and his feet were dragging behind him. There was no PNMP readily available. Staff went to another room to retrieve it upon request. In general, however, it appeared that there were improvements in staff attention to the details of proper positioning and compliance with the PNMPs compared to what was observed during the previous onsite review. Transfers observed were completed appropriately.	

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		Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. Staff training was reported to have been a major focus for OT/PT since the previous review. Transfers and lifting training offered in New Employee Orientation (NEO) was competency-based. Lifting was the only PNM-related area for which re-training was provided at the time of this review. Staff were required to take this retraining every two years. Individual-specific training was reported to be competency-based. Therapy staff provided inservice to available direct support staff and home managers or supervisors who in turn provided training for additional staff. Sample inservice sheets were submitted for the carry-over plans designed for programs to be implemented after discharging the individual from direct therapy. These specified that the competency requirement was "return demonstration" by direct support professionals. Recommendations were listed, but the specific skills that the staff were to demonstrate were not clearly listed. For example, in the case of Individual #9, per the inservice sheet dated 11/29/10, staff were to apply AFOs and orthopedic shoes with a helmet and gait belt for use during transfers. The methods used to apply the AFO or other equipment were not outlined, however, Individual #9 received direct therapy beginning 9/27/10 which, per the documentation, also included staff training during each therapy session. The plan was that once staff were competently able to demonstrate implementation, the program would be transitioned to direct support staff. This was an excellent strategy, but was not documented. The inservice forms submitted were samples only and did not include staff signatures as evidence that the training was completed. Instructions on the PNMP were not reviewed as the only PNMP submitted for Individual #9 was dated 8/30/10. The change to add AFOs and other transfer instructions was likely made after the document request was submitted. Details of staff performance are a critical piece of competency-based training. The activity analysis and performance standards should be clearly stated and the staff should be able to demonstrate each component of the task. For example, rather than just state that the staff completed a stand-pivot transfer correctly, this should be broken down into smaller steps, such as setup of the environment, communication with the individual, use of proper body mechanics, and other critical steps involved in the task. The activity analysis becomes the inservice outline and the check-off for competency. This would be particularly important when home managers and supervisors are responsible for training and establishing staff competency related to OT/PT plans. In addition, application of splints or AFOs should be more clearly outlined to describe each critical	

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		step involved. As stated above, pictures in the PNMPs should be large and clear enough to highlight detail for staff as this serves as a cue or reminder for staff of the critical components of the prescribed supports. As described above there was no mechanism to ensure the only individuals who were competency-trained were assigned to work with individuals at highest risk. **Standard: Staff verbalizes rationale for interventions.** In the examples above, staff were not consistently able to discuss the rationale behind recommended interventions. The rationale for interventions and supports was also not consistently included in the PNMP related to specific strategies. This is an important aspect of staff training as well as monitoring and coaching. The focus of the PNMP highlighted the overall risk issue for the individual as a rationale for the plan, but detail as to why a specific strategy was used was not usually indicated on the PNMP.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** The system for monitoring was revised and implemented beginning on 10/1/10. This new tier system was based on individual risk identification and included the PNMP and mealtime monitoring only. There were no other programs implemented by staff at the time of this review. The forms used were revised to address fit, availability, and condition of equipment, as well as availability of the PNMP and accurate implementation of the plan. The information was entered into a database/spreadsheet to track concerns and need for follow-up. Staff training had been completed on 9/29/10 with staff meetings conducted to address issues identified related to completion of the forms and the adherence to the schedule outlined. This system of self-examination was to be commended and was a good start to trend analysis of the findings. Once there is better consistency across staff with regard to documentation the data should be compiled and used to guide staff training, drills and follow-up. The database system should be as simple as possible, yet capable of capturing the findings of the monitors so that analysis is feasible and useful to the facility. Reports should not only be provided within the Habilitation Therapies department, but should be an aspect of the facility's overall QA system. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.**	Noncompliance

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		Since the majority of monitoring was conducted by PNMPCs and therapy technicians, it was primarily limited to availability and condition of equipment, rather than efficacy of the interventions in the PNMPs. The frequency of monitoring was driven by level of risk, though this will continue to be modified as the new risk assessment process is implemented. Another type of monitoring was called "requested" monitoring. This occurred as there was a need for increased intensity for observation related to a new program or change in an aspect of the plan. Findings, usually negative only, were entered by the monitor into a database to permit oversight by the licensed therapist for follow-up when issues were identified. When there was an SPO in place the therapist completed a review of the daily progress notes, completed an assessment as to the progress toward goal achievement, and submitted a written monthly summary. However, as stated above this was not integrated into the PSP process. **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 were no policies or guidelines to address the monitoring process. Procedures were communicated to staff via inservice training and validation of PNMPCs was completed by licensed clinicians. Differences in findings were discussed with inservice training for the PNMPCs. **Standard: On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.** Staff were monitored as an aspect of the individual specific monitoring conducted by PNMPCs. There was no tracking however to determine if this covered all staff who were responsible for implementation of PNMPs. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** A written SPO intervention plan was noted for each of the individuals who had received direct OT and/or PT. Implementation was documented daily by the therapy assistant and a monthly summary was written by the lead clinician. As described above, however, these were not well integrated with the PSP process. Documentation was maintained in the Habilitation Therapy section and did not occur in the integrated progress notes and status of these plans was not included in the quarterly QMRP reviews submitted.	

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		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, however, there was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. An example was described related to mealtime for Individual #4 in section O above. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** The database was used to track findings and follow-up. The system appeared to be complex with significant amounts of information included in the data base. This may require further changes as the system is utilized by the department. Further assessment of this process is indicated during the next review after staff are more consistent in completing the monitoring form and entering the data. **Standard: Data collection method is validated by the program's author(s).** Only direct treatment plans were implemented and the data was reported in a daily progress note and monthly summary. As more programs are developed for implementation by direct support staff, a system of data collections sheets with review and analysis by the therapy clinicians will be necessary to track progress on a routine basis. Validation of the accuracy of data collection should be a critical aspect of this review. This should be well-integrated into the PSP process. Further assessment in this area will be needed during future onsite reviews by the monitoring team.	

Recommendations:

1. The frequency of PNMP monitoring needs to be driven by risk level; those at highest risk must be monitored with sufficient frequency to ensure adequacy and efficacy of the supports provided as well as the accuracy of staff implementation of these supports. The recently developed spreadsheet system must be reviewed to ensure that it matches the newly assigned risk levels as the new Risk Assessment process is implemented over the next three months. All PNM-related risk issues must be considered when assigning needed frequency of PNMP and mealtime monitoring.

2. PNMP Coordinators continue to require structured, functional, competency-based training that includes didactic presentation of monitoring strategies and validation of competence through an ongoing "monitor the monitor" process, whereby they are observed during the monitoring

process and compared to a licensed clinician. Tracking of this should occur to clearly document that each PNMPC has received the same training and frequency of oversight and review.

3. Clarify the system and format of reports and other documentation to reduce redundancy for improved time management as well as consistency across clinicians and individuals as to how and where documentation should be completed. Rather than separate therapy issue-specific assessments documentation in the Integrated Progress Notes should be provided that state the issue, date of referral or onset of problem, report clinical data, state a rationale for interventions and measurable goals with consistent and ongoing analysis of the efficacy of interventions at a regular interval. In the event that the issue as a problem-oriented one, action by the clinician and the documentation must continue through to resolution of the concern.

4. Consider more extensive use of therapy techs and assistants to ensure that supports and services are readily available to those who require it.

5. Clinical staff should consider using larger photos with multiple views and must better scrutinize the clarity of detail so as to improve the PNMP as a resource to direct support staff.

6. There was duplication of information in the OT/PT assessments. Risk indicators should be considered in a more integrated manner throughout the report. The analysis of findings should cross all systems or clinical areas and should formulate the foundation or rationale for why specific aspects of the PNMP as well as other supports, service and interventions were indicated. These should then be listed as recommendations. The potential for skill acquisition sections should not be used predominately to justify barriers to learning new skills but rather interventions and supports that could teach new skills and mitigate barriers to learning.

SECTION Q: Dental Services	

	Steps Taken to Assess Compliance:
	
	Documents Reviewed:
	o DADS Policy #15: Dental Services, dated 8/17/10
	o EPSSLC Dental Services EPSSLC Dental Services - Oral Care for Enterally Fed Individuals
	o EPSSLC Dental Services - Suction Toothbrush and Patients Receiving Enteral Feedings
	o EPSSLC Dental Services - Oral Care
	o EPSSLC Dental Services - Criteria For General Anesthesia, 9/1/09
	o EPSSLC Dental Services - Dental/Medical Sedation and Restraint, 9/1/09
	o EPSSLC Dental Services - Dental Infection Control Policy
	o EPSSLC Dental Services - Crest Spin Brush Usage
	o EPSSLC Dental Services - Dental Sedation/ NPO for an Appointment
	o EPSSLC Dental Services - Hygiene Documentation
	o EPSSLC Dental Services - Dental Emergencies
	o EPSSLC Dental Services - Dental Desensitization
	o EPSSLC Dental Services - Dental Clinic Operations
	o EPSSLC Dental Services - Chlorhexidine Protocol
	o EPSSLC Dental Services - Attendance Problem Tracking Protocol
	o DADS Policy #012 Physical Nutritional Management, 12/17/09
	o EPSSLC Dental Data (May 2010–November 2010)
	    o New admissions
	    o Refused dental services
	    o Tooth extractions
	    o Dental emergencies
	    o Preventive dental care
	    o Restorative dental care
	    o Annual dental exam
	    o Initial/Comprehensive exam
	    o Sedation
	    o X-rays
	    o Restraints
	o Dental records for the individuals listed in Section L
	o List of pretreatment sedations, dosages, route and plans
	
	Interviews and Meetings Held:
	o Russell Redell, DDS, DADS Dental Director
	o Howard Pray, DDS, Contract Dentist
	o Jennifer Pacheco, RDH
	o Raquel Rodriquez, RDH
	o Salvador Molina, DO, Medical Director

	Observations Conducted: o Dental department o Dental clinic
	Facility Self-Assessment: The facility's POI for section Q indicated noncompliance with both provision items. Observations of clinics, interviews with the staff, and reviews of many documents indicated that progress has been made in both of these provision items of the Settlement Agreement. Significant problems were noted regarding the use of pretreatment sedation and a lack of desensitization plans. Suction toothbrushes were limited to those who receive enteral meals, the group at highest risk for pneumonia related to oral bacteria, when many others with dysphagia could benefit from improved oral care. The lack of valid and reliable data was evident in the discrepancies found among different documents. The monitoring team must currently agree with the facility's self-assessment of noncompliance.
	Summary of Monitor's Assessment: The new dental clinic at EPSSLC opened in May 2010, but the professional services of a dentist were not available until September 2010. Prior to September 2010, individuals were assessed by the hygienists and were seen in the community or in the dental clinic when a dentist from another SSLC was available. The addition of a dentist and dental assistant was progress. The format of dental data presented challenges to the monitoring team in determining the extent of services provided. The spreadsheet that had all data elements for all persons supported by the facility contained pages that duplicated data, but had different cottage numbers assigned. Determining the extent of chemical restraints from spreadsheet data was also problematic due to the data format. There was a column labeled sedation, but it appeared to be checked when pretreatment sedation, IV sedation, and nitrous were utilized. The comment section did not always clarify the type of sedation used. The spreadsheet also was not congruent with other data documents, such as the list of individuals who refused treatment or the list of individuals who received pretreatment sedation. Record reviews and interviews indicated that the individuals were beginning to receive more regular dental treatment. Initial assessments were being completed along with plans for future treatment. The facility had also recently implemented the use of suction toothbrushes and chlorhexadine for those individuals with enteral nutrition. The clinic staff reported there was no significant issue with failed appointments, yet refusals and missed appointments were documented. More importantly, a lack of recognition of this problem resulted in a failure to implement strategies to address the issue of failed appointments, especially given that 34% of the individuals had poor oral hygiene ratings.

	The use of pretreatment sedation was limited to those individuals with off campus appointments. The medical director expressed concerns about the use of pretreatment sedation and upon assuming the directorship had discontinued pretreatment sedation for most individuals being seen in the facility's dental clinic. In spite of concerns related to sedation, there were no formal desensitization plans in place at the time of the onsite visit. The majority of dental assessments indicated that sedation or general anesthesia was needed to complete exams and treatment.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The dental department staff was comprised of a contract dentist who worked three days per week, two full time dental hygienists, and one dental assistant. The state's dental director did not work onsite, but had frequent contact with the department through onsite visits and various meetings. Interviews were conducted with the medical director, dental director, contract dentist, and both dental hygienists. Overall, it appeared that most individuals were receiving regular treatment. It was reported that all individuals living at the facility had been seen by a dentist in the past 12 months. Emergency care was available, and documentation of emergency treatment was noted, for several individuals. Data submitted for the period May 2010 to November 2010 showed the following appointment data: • 380 preventive care visits • 25 restorative dental care visits • 12 extractions • 19 dental emergencies The dental department had recently implemented additional special supports for individuals at risk for aspiration. Suction toothbrushes were implemented for 14 individuals three weeks prior to the onsite review. All 14 individuals received enteral nutrition via gastric tube. Nursing services was responsible for oral care when a suction toothbrush was required. Other individuals at risk for aspiration, such as those with dysphagia were not utilizing suction brushes. The staff reported that were no dental policies that specifically addressed oral care for individuals with dysphagia and the use of suction toothbrushes. The DADS policy on physical and nutritional management required that individuals were in proper alignment during oral care. The dental manual contained a procedure Dental Care- Suction	Noncompliance

#	Provision	Assessment of Status	Compliance
		Toothbrushes for Patients Receiving Enteral Feedings.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	The hygienists reported that a database had been provided just prior to this onsite visit and that it was not yet fully functional. Data were requested on compliance with the annual assessment requirement. A document was provided which stated all individuals living at the facility were seen by a dentist within the past 12 months. Dental data were extracted from the spreadsheet provided and other documents requested. The data showed the following for the period reported. May – November 2010 | # Refused Dental Services | 26 Missed Appointment (other than refusals) | 8 Extractions | 12 Dental Emergencies | 19 Preventive Dental Care | 380 Restorative Dental Care | 25 Sedation | 29 X-rays | 83 During interviews with the dental director, dentist, and hygienists, it was reported that no pretreatment sedation was utilized for dental clinic appointments and there were no formal desensitization plans in place. The issue of data integrity was discussed in the summary section. Data provided showed that pretreatment sedation for dental appointments occurred 29 times from May 2010 to November 2010. During discussions with the medical director, he indicated that the liability of using pretreatment sedation in the facility was problematic. A review of the P&T Committee minutes indicated that significant discussion had occurred related to this issue. The minutes of the 9/23/10 meeting specifically cited a lack of staff training, equipment, and an infirmary as reasons this practice should be reviewed. Subsequent meeting minutes documented changes in protocols to reduce medication dosages and adding additional medications including Haldol, Cogentin, and Ativan. The need for a medical representative on HRC was also discussed. While there were no formal desensitization plans, there was evidence that informal plans or strategies were occurring. The clinic staff reported, during interviews, that missed appointments were not problematic due to the fact that the hygienist often went to the homes to pick up the individuals. It was reported that there were 10 refusals and two no shows. There was a total of 34 refusals and missed appointments. It was reported that there was frequent	Noncompliance

#	Provision	Assessment of Status	Compliance
		contact between the hygienists and psychology staff in an effort to resolve the issue of refusals. Several emails were reviewed that indicated there were often discussions with QMRPs to this effect. Reasons cited for missed appointments included "direct care didn't bring individual to clinic" and "no show." Some details are presented below. <u>Individual #157</u> • Date: 9/10/10 (date of email correspondence) • Reason: Noncompliance of direct care staff to bring individual to dental appointment <u>Individual #37</u> • Date: 5/10/10 • Reason: Direct care did not bring individual to dental appointment. Appointment was for annual dental. This was the first day of the new dental clinic. • Rescheduled date: 5/13/10 for comprehensive exam and periodontal probing. Individual was seen for additional appointment x-rays were taken on 7/14/10. Individual was on a recall appointment system. <u>Individual #3</u> • Date: 5/10/10 • Reason: Direct care did not bring individual to dental appointment. Appointment was for annual dental. This was the first day of the new dental clinic. • Rescheduled date: 5/20/10 for annual dental, comprehensive exam, and was seen for additional appointments. <u>Individual #155</u> • Date: 5/11/10 • Reason: Direct care did not bring individual to dental appointment. Appointment was for annual dental. This was the first day of the new dental clinic. • Rescheduled date: 5/25/10 for exam and attempt desensitization. Dental staff made additional attempt appointments. <u>Individual #54</u> • Date: 5/12/10 • Reason: Direct care did not bring individual to dental appointment.	

#	Provision	Assessment of Status	Compliance
		Appointment was for annual dental. This was the first day of the new dental clinic. • Rescheduled date: 5/17/10 an oral exam was done. Additional appointments for cleanings and scaling had been completed. X-rays were taken on 12/8/10. Individual #14 • Date: 5/12/10 • Reason: Direct care did not bring individual to dental appointment. Appointment was for annual dental. • Rescheduled date: 7/7/10 for initial exam. She had additional appointments. X-rays were taken on 7/13/10. Cleaning appointment was completed on 8/11/10. The dental clinic did not track the oral hygiene ratings for all individuals. A document containing all persons with a rating of poor was provided. Thirty-four percent of individuals living at the facility had poor oral hygiene ratings. When asked about possible causes, the dental hygienists reported that oral hygiene in the homes was not being done as required. The clinic attempted to overcome this deficiency by bring individuals back to clinic more often. The hygienists also reported that they started to increase training of direct care professionals by providing training in the cottages on Saturdays and Sundays. Staff were required to perform a return demonstration. There was no over-arching agency strategy in place to address the lack of oral hygiene in the homes.	

Recommendations:

1. The facility must address the issue of oral hygiene. The approach must be comprehensive and include training to direct care professionals on oral hygiene and issues related to the use of restraints.

2. The issue of pretreatment sedation must be addressed. The goal should not be to eliminate pretreatment sedation, but to utilize the least restrictive approach. The PSTs should be aggressive in ensuring that individuals who have failed appointments or who have use of pretreatment sedation are evaluated for appropriateness of desensitization plans. When individuals have desensitization plans implemented, the PSTs should ensure that the plan is being followed to determine success or failure.

3. When the least restrictive methods fail and pretreatment sedation is required, it should be approached cautiously. There should be a thorough review of all medications by pharmacy, medical and psychiatry each time sedation will be administered. The stacking effect of sedation medications upon regular medications must be taken into consideration.

4. The dental clinic should fully implement the database. All data elements required within the Settlement Agreement should be included.

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 Clinical Staff list and PNMT members o CVs for Henry Kielb, MS, CCC/SLP o State License verification for clinical staff o Continuing Education documentation for clinical staff o EPSSLC POI and Supplement o Presentation Books for Sections O, P and R o NEO Training modules with checklists and competency tests o Augmentative Staff Refresher Training o AAC Equipment list (11/23/10) o List of individuals receiving direct speech services o Clinical Factors Will Drive AAC Assessments o Communication Matrix Profile Potential o Suggested Optimal Communication Strategies – Correlated to Language Levels o Online Communication Matrix handbook o AAC Assessment template o Strategies for Optimal Communication monitoring form o SLP Annual Evals/Assessments and AAC Devices/Communication Dictionary Spreadsheet 2010 o Completed Strategies for Optimal Communication Monitoring Forms submitted o AAC Monitoring Forms submitted o Monitoring results Spreadsheet o Trial PNMP Risk Monitoring spreadsheet o List of individuals monitored in October and November 2010 o Requested or Observed Monitoring Form o PNMP Monitoring Form o Completed monitoring sheets submitted o Completed Requested or Observed Monitoring forms submitted o List of Individuals with Wheelchair as Primary Mobility o List of Individuals with Wheelchair for Transport o PNMPs submitted o Communication assessments and PSPs for the following: ▪ Individual #50 (7/5/10), Individual #75 (7/12/10), Individual #188 (7/12/10), Individual #92 (8/2/10), Individual #23 (10/1/10), Individual #15 (10/14/10), Individual #81 (10/19/10), Individual #110 (10/19/10), Individual #93 (9/27/10), Individual #46 (9/21/10), Individual #58 (9/10/10), Individual #125 (10/15/10) and Individual #114 (10/19/10) o Speech services documentation for the following:

	- Individual #172, Individual #56, Individual #93, Individual #79, Individual #86, Individual #71, Individual #115, Individual #63 and Individual #92. o Personal Records for sample of individuals including: Comprehensive Nursing Assessments, Nursing Quarterlies, current list of medications, PNMPs for last 12 months, Dining Plans for last 12 months, contents Habilitation Therapy tab, Annual Nutrition Assessments and quarterlies, PSP and addendums, PSP quarterly reviews, Incident/Injury reports for fractures, choking or swallowing events, hospitalizations records, MBSS reports and follow-up by SLP, contents Gastroenterology tab, contents Orthopedics tab, Integrated Progress Notes from 1/1/10 to 1/4/11 and, monitoring sheets completed for last six months as submitted for: • Individual #39, Individual #84, Individual #97, Individual #115, Individual #15, Individual #116, Individual #178, Individual #103, Individual #119, Individual #123, Individual #152, Individual #78, Individual #33, Individual #113, Individual #28, Individual #74, Individual #4, Individual #13, Individual #132, Individual #12 and Individual #73 Interviews and Meetings Held: o Anderson Hicks, OTR, Director of Habilitation Therapies o Henry Kielb, MA, CCC-SLP o Bahola Puentes-Polo, MS, CCC-SLP o Mary Mooney, MA, CCC-SLP o Karin De La Fuente, MS, CCC/SLP o Speech technicians/PNMPCs o Various Supervisors and Direct Support Staff o Meeting with OTs and PTs o Meeting with SLPs Observations Conducted: o Living areas o Dining rooms o Day Programs o Habilitation Therapies clinic areas
	Facility Self-Assessment: EPSSLC's self-assessment identified noncompliance for all items of this provision. This self-assessment was consistent with the monitoring team's assessment of noncompliance.
	Summary of Monitor's Assessment: Many individuals who needed AAC and other communication supports and services did not receive them at the time of this review. There were at least 84 individuals who were identified as nonverbal and though others were listed as verbal, a number of them did not appear to be functional communicators in a variety of contexts and environments and would be considered to have significant communication limitations.

	It was of concern that only 4% (five out of 134) of the individuals living at EPSSLC received direct communication services (2% of those who were considered non-verbal). No more than 18 individuals had individual AAC devices provided to them. While it was great that community systems (e.g., wallboards) had been provided, the focus needed to shift to more individual systems that were meaningful and functional. A few AAC assessments had been completed that appeared to yield more individualized and functional supports for communication, including AAC systems, and were significantly more thorough. The only clinician who completed these worked only approximately 10 hours a week. This area was severely deficient and, as a result, numerous individuals at EPSSLC continued to be 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. The Communication Skills assessment format had been revised, yet the content in many cases was far from thorough. In most cases, the assessments did not address expansion of current abilities or the development of new skills beyond the standard Communication Books and the Communication Picture Wallboards. There was insufficient information and specificity upon which to base potential for expansion of existing skills and to establish individual 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. The new sections added since the previous review included sections titled "Strategies for Optimal Communication" and "Communication Strategies and the Behavioral Support Plan." The first new section was intended to provide additional strategies for staff use while interacting with the individual. This was a good concept, but the strategies were not sufficiently individualized. The other new section in the assessment format was intended to address the issue of integrating communication issues with the Behavior Support Plan, but failed to meet the intent of the Settlement Agreement. There was no Master Plan related to how the facility had prioritized completion of comprehensive assessments to identify and provide appropriate interventions, AAC, and other communication supports for the individuals living at EPSSLC. While the POI continued to cite the lack of staff, there was a significant lack of effort to address AAC with the existing resources as evidenced by the inadequate AAC assessment sections of the Communication Skills Updates reviewed. Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occur in order to promote communication skill acquisition. There were few, if any, formal communication programs (as also noted in sections F, S, and T of this report).

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**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.** At the time of the onsite monitoring review, SLP staffing was as follows: Henry Kielb, MA, CCC, SLP Karin De La Fuente, MS, CCC/SLP Bahola Puentes-Polo, MS, CCC/SLP Mary Mooney, MA, CCC/SLP Mr. Kielb was a full time state employee and the other clinicians were part-time contract. Per Andy Hicks, Habilitation Therapy Director, there were plans to increase the contract hours for Ms. Puentes-Polo from the current 34 hours to 40 hours. Ms. De La Fuente generally provided services approximately 10 hours a week, in the late afternoon on Monday and Wednesday and on weekends. By report, this may increase over the next few months. Mary Mooney had worked full time for 13 weeks and then 10 hours per week for 13 weeks. There was an interruption in services for approximately 30 days to work out a new contract which was now in place for 10 hours a week. There were no speech assistants employed at the time of this review though there were three speech technicians, two working full time, and the third worked half-time as a speech aide and half-time as a PNMP Coordinator. One of the full time technicians was currently out on medical leave. The other had previously worked as a special education teacher and was in the position of RTT-4. Evidence of current licenses (4/4) was submitted for all clinicians, though CVs were not (1/4). There was no evidence of communication-related continuing education submitted for the SLPs in the last six months (0/4). This was also a finding from the review conducted in July 2010 with no evidence of communication-related continuing education noted for the speech clinicians since January 2010. Also the review in January 2010 found that the single SLP at the time, Henry Kielb, MA, CCC, SLP, had not participated in any communication-related continuing education at that time during the entire previous year. While the clinicians held licenses to practice in the State of Texas and they were reported to have experience with individuals with developmental disabilities and AAC, it was not possible to validate their experience and qualifications in these areas. There was one full-time clinician, three part-time clinicians (approximately 2.4 FTEs), two full-time technicians, and one part-time technician (2.5 FTEs) responsible for the communication and mealtime needs of the 134 individuals living at EPSSLC. This was an increase in staffing since the previous review, however, adequate and appropriate communication services were not provided for the individuals who	Noncompliance

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		presented with significant communication deficits at EPSSLC. **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.** During a group interview, the staff reported that not all individuals who needed AAC and other communication supports and services received them at the time of this review. An undated spreadsheet submitted included 141 individuals of whom 90 were listed as non-verbal. There were three individuals who were deceased (Individual #29, Individual #106 and Individual #41) and two others who had moved from EPSSLC (Individual #124 and Individual #150). Individual #87, Individual #22, and Individual #62 were not listed on the census list and their disposition was not known to the monitoring team. Individual #191 was listed as a resident on the list submitted, however, by report he had not been seen by Habilitation Therapy staff and was not included in the Master Plan spreadsheet. Of these individuals, all were described as nonverbal with the exception of Individual #106 and Individual #62. Communication skills for Individual #191 had not been identified. With these omissions, the number of individuals listed as nonverbal was approximately 84 or at least 63% of the current census. This was consistent with the numbers reported during the previous review in July 2010. Records of 20 individuals were reviewed as well as communication-related assessments for another 14 individuals. Most of these indicated that the individuals presented with significant communication deficits. Nine individuals were reported to be at least partially verbal with some level of expressive and/or receptive communication skills, though most of these were minimally functional in a variety of contexts and environments per their assessments. Per the Annual Communication Evaluation/Assessments and AAC Device/Communication Dictionary Spreadsheet 2010, 74% (25/34) were identified as nonverbal with significant expressive and/or receptive language deficits. Though the other nine individuals were listed as verbal, in some cases, this appeared to be minimal as in the case of Individual #97 and Individual #113. The assessments for these nine individuals also identified concerns related to functional communication across contexts and environments (Individual #113 and Individual #15), communication-related behavior concerns (Individual #119, Individual #73, Individual #13, Individual #15 and Individual #74) , and/or discrepancies between understanding language and expression of language to communicate (Individual #178, Individual #97, Individual #73, Individual #13 and Individual #39.	

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		Surprisingly: • Only five (15%) of the 34 individuals for whom assessments were submitted were recommended for communication supports and services designed to improve or augment existing language and communication skills. • Direct speech services were recommended for only three individuals (Individual #39, Individual #63, and Individual #92) in the 34 assessments submitted and reviewed. • Consultative communication-related services were recommended for only Individual #50, and for environmental control for Individual #114 and Individual #125. Per a list submitted, there were, however, nine individuals listed as receiving direct speech therapy at the time of this review (Individual #92, Individual #115, Individual #93, Individual #71, Individual #63, Individual #56, Individual #86, Individual #172 and Individual #79). Interventions were related to oral intake for three of these individuals (Individual #93, Individual #71 and Individual #115). Communication-related interventions were provided to Individual #92, though progress notes were submitted only for September 2010 and October 2010 with no further documentation of services provided since that time. Direct speech therapy was reported to be pending physician approval for Individual #63 related to sign language since 12/3/10. Four others participated in a group called, the Speech Therapy Syntax Writing Group (Individual #56, Individual #86, Individual #172 and Individual #79). The group was conducted two times per month by a SLP for 30-45 minute sessions. This direct therapy related to copying words and phrases, generating written communication, writing legibility, and mailing letters and greeting cards. By report, this group had been conducted for a number of years for these same individuals. Though it was recommended that Individual #39 also participate in direct speech therapy one time a week, in his Communication Skills Update on 5/29/10 and in his AAC assessment dated 8/3/10, there was no evidence that he actually had received this service. There was a SPO submitted dated 8/25/10 that included a goal for increased functional sign language skills by 11/30/10, however, there were no progress notes submitted. This was not listed in his PSP or addendums. He was not included on the list submitted related to those who received speech therapy and there was no other documentation in his record related to this service. As stated above, there were at least 84 individuals who were identified as nonverbal and though others were listed as verbal, a number of them did not appear to be functional communicators in a variety of contexts and environments and would be considered to	

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		have significant communication limitations. It was of concern that only 4% (5/134) of the individuals living at EPSSLC received direct communication services. The four individuals identified above who participated in the writing group were identified as verbal, yet there were numerous other individuals who were identified as nonverbal, were not functional communicators, or had related behavioral concerns and did not receive supports beyond a communication book and dictionary. While this was positive for these four individuals, this same group had been in place for a number of years, yet there was no evidence of established functional measurable goals and though requested there were no assessments or progress notes related to this direct service submitted for any of the four individuals. There were numerous others who did not have a basic functional communication system and did not receive any level of supports and services beyond a communication dictionary, a communication book and, in some cases, community AAC devices. Of the individuals included in the sample for review, there were only three individuals who had been recommended for direct supports and services and only one who had actually received them per the documentation submitted. As stated above there was no evidence that this individual had received these services beyond October 2010. Consultative communication-related services were recommended for only one individual, Individual #50. As he was not listed as receiving speech therapy, he was not included in the review sample and it was not possible to determine if consultation was provided as recommended in his assessment dated 7/5/10. There was no evidence that SPOs designed and monitored by SLPs with implementation by technicians, day program staff or direct support professionals were in place to expand or enhance existing communication skills for any of the individuals reviewed. Per a list submitted titled AAC Equipment and dated 11/23/10, there were only seven individuals listed with AAC equipment other than a communication book or environmental control device (Individual #92, Individual #11, Individual #21, Individual #183, Individual #40, Individual #125 and Individual #63). Equipment listed included the following: Go Talk 20 (1), talking photo album (4) and Hip Talker (2) for these individuals. This represented a <u>reduction</u> from 18 individuals with similar AAC devices at the time of the previous review in July 2010. An additional undated spreadsheet submitted for the current review listed 19 individuals with AAC devices. Three of these devices were listed for individuals who were now deceased. The remaining 16 devices were identified as talking photo albums (12), Hip Talkers (3) and a Go Talk 20 (1). It was not clear as to which of these tracking systems was accurate. At any rate, it was of concern to the monitoring team that the number of AAC systems and other communication supports provided to individuals remained unchanged in the last year at	

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		best and perhaps even decreased despite the significant number of individuals who were identified as nonverbal and/or with significant communication deficits.	
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.	**Standard: All individuals in need of AAC were identified as being in need of AAC.** The five most current SLP assessments with the related PSPs were requested by the monitoring team. Assessments were submitted as follows: Mary Mooney, MA, CCC/SLP • Individual #50 (7/5/10) • Individual #75 (7/12/10) • Individual #188 (7/12/10) • Individual #92 (8/2/10) • Individual #39 (8/3/10, also part of the record sample requested, see below) Henry Kielb, MA, CCC/SLP • Individual #74 (9/30/10, also part of the record sample requested, see below) • Individual #23 (10/1/10) • Individual #15 (10/14/10) • Individual #81 (10/19/10) • Individual #110 (10/19/10) • Individual #93 (9/27/10, this unsigned assessment was submitted as completed by Bahola Puentes-Polo, but appeared to have been completed by Mr. Kielb) Bahola Puentes-Polo, MS, CCC-SLP • Individual #46 (9/21/10) • Individual #58 (9/10/10) • Individual #125 (10/15/10) • Individual #114 (10/19/10) It was of concern that that, in some cases, the most current assessments available for submission were over four months old. PSPs were submitted for each of the individuals, though nine were marked as drafts and were incomplete, though the meetings had been held in October 2010 and November 2010. There were additional assessments submitted as part of the sample records request and included the following: • Individual #132 (11/15/10) • Individual #123 (4/15/10) • Individual #152 (1/27/10)	Noncompliance

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		• Individual #119 (6/1/10) • Individual #116 (4/5/10) • Individual #15 (6/12/10) • Individual #115 (5/26/10) • Individual #97 (7/17/09) • Individual #84 (1/28/10) • Individual #12 (1/25/10) • Individual #73 (6/2/10) • Individual #4 (6/21/10) • Individual #28 (4/20/10) • Individual #113 (5/3/10) • Individual #33 (9/14/10) • Individual #78 (8/6/10) • Individual #39 (5/29/10) • Individual #178 (3/20/10) • Individual #74 (10/28/09 and 9/30/10) • Individual #13 (3/20/10) The Communication Skills Update included the following subheadings: I. Reason for Referral/Background Information II. Current Update Results/Assessments • Hearing and Vision • Oral Motor Function/Feeding • Communication Skills • Receptive Language • Expressive Language • Pragmatic Social Language • Strategies for Optimal Communication • Communication Strategies and the Behavioral Support Plan • Augmentative Communication III. Adaptive Support Equipment IV. Living Options • Summary/Clinical Impressions V. Recommendations While the headings suggested, and the POI suggested, that that this was a more comprehensive communication assessment, the content in many cases was far from thorough. This format was generally consistent between Ms. Puentes-Polo and Mr. Kielb for submitted assessments completed from August 2010 through November 2010. The	

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		new sections added to the assessment format, since the previous review, included sections titled "Strategies for Optimal Communication" and "Communication Strategies and the Behavioral Support Plan". The first new section was intended to provide additional strategies for staff use while interacting with the individual and, as of 9/1/10, were to be included in the PNMP. While this was an excellent idea, unfortunately there were only two sets of similar strategies in the assessments completed by Mr. Kielb. The eight assessments submitted for Individual #15, Individual #81, Individual #74, Individual #23, Individual #132, Individual #33, Individual #110 and Individual #93 had one of two sets of strategies offered for use by staff rather than suggestions that were individualized. These strategies appeared to be more individualized in the assessments completed by Ms. Puentes-Polo for Individual #58, Individual #78, Individual #46, Individual #125 and Individual #114. Merely including suggestions for how staff should interact with an individual in the annual assessment would not meet the intent of the Settlement Agreement provision items related to appropriate and adequate communication supports and services. Though the assessments for Individual #132 and Individual #33 had been completed after 9/1/10 (11/15/10 and 9/14/10, respectively), the communication strategies identified in the assessments were not listed on their PNMPs. The other new section in the assessment format was intended to address the issue of integrating communication issues with the Behavior Support Plan. This was noted in the Communication Skills Updates submitted and reviewed for Individual #110, Individual #132, Individual #23, Individual #74, Individual #81, Individual #15, and Individual #78. Unfortunately, this section did not reflect integration of communication and behavioral supports and services, but rather the speech clinician reported the target behaviors identified in the BSP with an opinion of the BSP and/or its implementation related to communication issues. Including verbiage in the communication assessment would not suffice for integration of supports and services as is the intent of the Settlement Agreement . Some examples included: • Individual #74: In the Communication Skills Update on 9/30/10, the SLP reported zero incidences of self-injurious behaviors from November 2008 to September 2009 with 15 to 30 episodes of agitation during the same period. The SLP then reported observation of staff interactions during episodes of agitation and stated that the BSP was "optimal in regard to communication and actions in general." It was of concern that the clinician cited data that were over a year old and the descriptions offered were anecdotal. Though the Strategies for Optimal Communication and the communication strategies described in the BSP appeared to be consistent, there was no evidence that there was collaboration in the	

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		development of these by both speech and psychology. The SLP did not recommend any interventions to enhance or expand Individual #74's current skill levels related to communication. The PSP was dated 10/19/10, but was incomplete and marked as a draft. • Individual #81: The SLP again described the target behaviors identified in the BSP (11/30/09). The clinician also offered an opinion that the BSP was "optimal in regard to appropriate and realistic communication considering the communication disorder present." No interventions were identified to enhance or expand Individual #81's current communication skill levels. The PSP was dated 11/3/10, but was incomplete and marked as a draft. • Individual #15: The SLP again described the target behaviors in the BSP (12/14/09) and further reported that the SLP had noted that Individual #15 was more relaxed and had not observed any self-injurious behaviors. This reporting was anecdotal rather than data driven and it did not appear that the clinician was aware of the data being collected by psychology. The clinician offered an opinion related to the BSP instructions to offer a detailed explanation to Individual #15 as to why it was important to engage in specific tasks. This was not advised by the SLP due to his "reduced receptive language ability." There was no evidence of collaboration between the speech clinician and psychology regarding this issue and there were no recommendations for interventions to enhance or expand Individual #15's current communication skill levels. The PSP was dated 11/1/10 but was incomplete and marked as a draft. • Individual #132: The SLP described the target behaviors in the BSP developed in January 2010. The SLP stated that "perhaps when the next BSP is developed, Psychology and Speech Pathology can collaborate in an attempt to use communication that is more understandable to Individual #132 (based upon structured testing)." No PSP was submitted for Individual #132. It was of concern that this was not attempted at the time of this assessment and was in the text of the assessment, but not listed as a recommendation. Again, there was no recommendation for interventions to enhance or expand his current communication levels. The section on Augmentative Communication currently completed by the speech clinicians in the Communication Skills Updates generally reported only that there was a communication dictionary, a Communication Picture Book, and community wallboards that should be used with the individual and then these were repeated as recommendations. The language used in this section was exactly or essentially the same wording for nearly all reports written by Mr. Kielb with no evidence of actual assessment of the potential or	

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		need for AAC (Individual #23, Individual #132, Individual #74, Individual #110, Individual #15, Individual #81, Individual #123, Individual #152, Individual #28, Individual #13, Individual #73, Individual #84, Individual #93, Individual #33, Individual #115, Individual #15, Individual #116 and Individual #119. There was no evidence of assessment of whether these supports were appropriate and were used effectively by the individual and/or staff. There was no evidence that the supports were personalized to the individual, but rather were the same for everyone living at EPSSLC. The implementation of these supports was left entirely to the staff with no evidence of participation by the SLP related to training, modeling, or monitoring integration of these systems into the daily routine. In only a few cases was a more individualized approach attempted, though follow-up and supports were seriously lacking. For example: • An object communication board was recommended for Individual #12 instead of the canned Communication Picture Book provided to everyone else because she was blind, per her assessment dated 1/25/10. There was no evidence that Mr. Kielb had conducted any trials with Individual #12 or attempted to conduct an inventory of objects that would be meaningful to her across her day. The recommendation was that there should be a meeting of OT, PT, SLP, and DCPs to determine which objects would be appropriate communication aides within one month of the PSP meeting. Though this was documented in the PSP under the Speech Assessment section, there was no service objective developed and no evidence of a meeting or provision of such a device for Individual #12. Her PNMPs listed the standard Communication Book as assistive equipment and staff were instructed to "use manual guidance and communication book as needed throughout her daily activities" though it had been reported that she could not see the book and required a different device. This speech clinician failed to meet the communication needs for this individual. • Individual #178 was provided a Tech Talker (date issued was not reported in the assessment dated 3/3/10). After it was issued, it was determined that he lacked sufficient power to activate the buttons to trigger the messages. In addition, it was reported that he appeared disinterested in using a high tech device. Rationale cited included that staff anticipated many of his needs and he made requests related to toileting and food regularly. A different device, the Hip Talk, was provided on 5/5/09 with social statements and questions. Again, it was reported that he did not show interest in the device. These devices appeared to be issued with limited to no assessment, trials, or training provided.	

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		Staff anticipation of needs should not be the rationale for not needing a communication system, but rather highlight the need for extensive staff training and structured programming to create communication opportunities for making choices and requests during routine activities. The SLP stated that he would continue to look into other types of systems that would be more effective for Individual #178. There was no evidence in his personal record that this was pursued during the last year. • Per his assessment dated 5/3/10, Individual #113 was provided the routine supports provided to everyone living at EPSSLC including a Communication Picture Book and the Communication Picture Wallboards installed in his home. There was an SPO, dated 10/5/09, related to use of a talking photo album intended for short term training. It was reported that he was issued a Talking Photo Album on 11/19/09. In his most current assessment, there was no review of the intervention provided, staff training, how the device was used, and whether it was effective for Individual #113. The assessment stated it should be used daily following the directions and schedule for use. While it was listed on the PNMP as assistive equipment, there were no instructions for the use of the device noted. There were no other instructional plans related to the talking photo album submitted with his records. • In his assessment dated 5/29/10, it was stated that Individual #39 had received Speech Therapy the previous year for use of a mid-level augmentative device. There was no discussion of the type of therapy provided, the functional goals, or his progress related to this intervention. Rather, the clinician stated that it was not appropriate to proceed with therapy to address verbalization, and a Hip Talk device was issued in May 2009. It was discontinued due to strong resistance to using it and he was recommended for group therapy for use of sign language. There was no evidence that this had been provided to him. A subsequent AAC assessment by Mary Mooney, MS, CCC-SLP, on 8/3/10 confirmed that he was able to communicate functionally and effectively using conventional gestures, signs, leading behaviors, and spoken words. It was recommended, however, that, to expand his skills, there should be a greater focus on the use of standard sign language and conventional gestures. Direct and indirect interventions were recommended to address this identified need. An SPO was developed on 8/25/10. The plan included a trial implementation for one month by the speech technicians and also by direct support staff in the workshop environment. Documentation was to include monthly progress notes. There was no evidence in his personal record that these interventions had been provided to him. As stated above, there were approximately 84 individuals who were identified as nonverbal and, as such, would potentially benefit from AAC and/or other communication supports and services. In addition, a number of individuals for whom assessments were	

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		submitted were identified as verbal, but were described with limited functional communication skills in a variety of contexts and environments and would potentially also benefit from communication supports and services. Recommendations related to communication for 24 of these individuals were essentially the same and included: • No Speech Therapy needed at this time. • Continue with the current PNMP, but add concisely worded "Strategies for Optimal Communication" to the communication section of the PNMP. • Staff should continue with the "Augmentative Communication Picture Books" and the "Communication Picture Wallboards" with individual to maintain or expand current level of communication skills through daily purposeful interaction. • Staff and family members should read the Communication Dictionary 2010 so that they can be aware of the specifics of how individual communicates in various daily situations. Each of these assessments was completed by Mr. Kielb or Ms. Puentes-Polo. Five other assessments by these same clinicians included those for Individual #39 (5/29/10), Individual #125 (10/15/10), Individual #114 (10/19/10), Individual #12 (1/25/10) , and Individual #78 (8/6/10). Recommendations, in addition to those listed above, were related to a mini-staffing (PSPA) to discuss optimal AAC board or objects for Individual #12, consultative services by the SLP related to environmental control devices for Individual #125 and Individual #114, a PST meeting to discuss the need to increase expressive vocabulary to address behavior concerns for Individual #78, and a recommendation of group therapy to increase use of sign language for Individual #39. The assessments completed by Mary Mooney, MA, CCC-SLP were titled Augmentative/Alternative Communication Assessments. By report, individuals were referred to her for more specialized AAC assessments. They were of a different format than the other assessments submitted and recommendations were as follows: • Individual #50 (7/5/10): Four-week trial of consultative speech therapy to expand expressive communication skills. • Individual #92 (8/2/10): Re-evaluation secondary to change in status. Recommendations included modifications to her existing Go Talk 20 device to secure it to her laptray, modifications of overlays and icons, staff training, and an SPO related to the use of her device. • Individual #75 (7/12/10): Probes for activation of AAC switches that provide tactile reward or sensation and opportunities to make choices during mealtimes. • Individual #188 (7/12/10): Staff inservice regarding opportunities for choice making at mealtimes, in her home and at work. • Individual #39 (8/3/10): Per this AAC assessment, Individual #39 had been	

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		referred for further evaluation related to sign language on 1/11/10. An additional recommendation for this service was also noted in the Communication Skills Update on 5/29/10. The AAC assessment was completed nearly seven months after the need was identified. This assessment also recommended individual direct speech therapy one time per week to increase his use of sign language as well as indirect therapy to include communication partners in his daily routine. As described above, it was unclear if this had been, or continued to be, provided to Individual #39. While these five assessments appeared to yield more individualized and functional supports for communication and were significantly more thorough, there were no more current assessments submitted by this clinician and, as such, it appeared that there had been no additional assessments of this kind since July 2010 and August 2010. Also Ms. Mooney worked approximately 10 hours a week and it was of concern that she was the primary clinician conducting this type of more in-depth assessment for specific communication supports and services. There was no Master Plan related to how the facility had prioritized completion of comprehensive assessments to identify and provide appropriate interventions, AAC, and other communication supports for the individuals living at EPSSLC. The current spreadsheet merely reported when the last speech evaluation was completed and when the next annual assessment was due. There was no apparent plan as to how to complete the more specialized assessments as currently done by Ms. Mooney for all individuals that would require them. At the time of this onsite review, it was reported that not all individuals with a need for an AAC device had been identified to date. While the staff reported that each individual received an AAC assessment at the time of his or her annual communication update for the PSP, the assessment in those reports were generally inadequate. Also in some cases where AAC was recommended, implementation was not provided in a timely manner. As stated above, there were at least 84 individuals who were considered to be nonverbal. At the most, only 18 individuals had been provided any type of AAC system and two of those were identified as verbal per the spreadsheet submitted. Most all individuals had a Communication Book, but these were not adequately individualized and the appropriateness for each had not been sufficiently explored. Of those individuals in the sample, 25 out of 34 (74%) of the annual updates did not meet the minimum practice standards for AAC assessment. Most of these stated that the individual had a Communication Book, Communication Dictionary, and access to Communication Picture Wallboards. These were essentially the same or very similar	

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		systems for each individual and were predominately guides for staff rather than systems to be used by the individual themselves. They were also generally not focused on expansion of communication skills or new skill acquisition. There was no evidence of any SPOs related to these or other communication systems for individuals reviewed in the sample. **Standard: All people received a communication screening or assessment within 30 days of admission, readmission, or change in status.** Per the list submitted, there had been two admissions to EPSSLC since 6/1/10 and included Individual #191 and Individual #144. The spreadsheet submitted indicated that Individual #144 had received a communication assessment on 8/9/10, well-within the 30-day time frame. This report was not reviewed by the monitoring team. Per Andy Hicks, Individual #191 had not been assessed by Habilitation Therapy and that he had not been admitted. He was not included on the spreadsheet maintained by Speech Therapy to track assessments and AAC equipment. There was no indication that individuals were re- evaluated related to communication upon change in status with the exception of Individual #92 who received her annual assessment on 1/29/10 and then subsequently on 8/2/10. The assessment on that date was an AAC Communication Assessment and was completed, by report, due to changes in her residence, hospitalization, gastrostomy tube placement, and non-oral status since the previous PSP meeting. However, per her PSP, she had a tube in place at that time and was NPO. She also lived in 503A as she did at the time of the re-evaluation, so the rationale for re-assessment due to status change was unclear. That said, the re-assessment was thorough and resulted in a variety of supports, services and interventions provided to Individual #92 that were not available to her previously. **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.** Each of the assessments reviewed generally addressed both verbal and nonverbal skills. In some cases, 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 often not clear as to how	

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		effective the current methods used by each individual were within their daily routine. In most cases, the Communication Skills Updates (26 out of 29, that is, 90%) did not address expansion of current abilities or the development of new skills beyond the standard Communication Picture Books and the Communication Wallboards. The Strategies for Optimal Communication were not sufficiently individualized and were available only for those 12 individuals in the sample reviewed whose assessment had been completed after 9/1/10. Of these, the strategies had not been included in the PNMPs for two individuals as described above. While the concept was a good one, these strategies were focused on what staff could do to ensure that their communications were more readily understood by the individual and did not address expansion or development of expressive communication skills. There was very limited evidence of more specific interventions intended to specifically increase communication skills through structured clinician-designed programs and interventions. Few of the records reviewed addressed the need for further assessment in Augmentative Communication. This area was severely deficient and, as a result, numerous individuals at EPSSLC continued to be 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 cite the lack of staff, there was a significant lack of effort to address AAC with the existing resources as evidenced by the inadequate AAC assessment sections of the Communication Skills Updates reviewed. It had been identified by Speech staff in July 2010 that the plan was to review everyone over the course of the next year with regard to AAC. It was of concern that recent updates were limited as to the assessment of AAC and very few individuals had received the more in-depth assessments completed by Ms. Mooney since that time. There were 24 of 34 assessments that specifically stated that no speech therapy was indicated and each of these recommended the typical communication books, dictionaries, and wallboards. Six others did not specify whether direct services were required, but five of these recommended some level of consultation or other indirect service other than the book, dictionary, or wallboard (Individual #78, Individual #125, Individual #12, Individual #114, and Individual #39). The six Augmentative/Alternate Communication Assessments submitted (Individual #39, Individual #92, Individual #63, Individual #75, Individual #188 and Individual #50) more clearly specified the need for direct and/or indirect services with a rationale. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured**	

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		relevance and appropriateness of goals. All individuals received an annual Communication Skills Update. There were six individuals listed as participating in direct speech therapy. One was reported to be pending doctor's orders (Individual #63) and another (Individual #92) had participated in direct therapy through 10/31/10, per the documentation. There was no evidence that this had continued. She had not been discharged, per the progress note, at that time, but there was no documentation submitted for an active SPO at the time of this review. The other four individuals (Individual #172, Individual #79, Individual #86 and Individual #56) reportedly continued to participate in the writing group conducted by the SLP, but no documentation as to measurable goals, progress, or any documentation as to their participation in this group was submitted as requested. Other individuals received indirect supports via a communication dictionary, book, or picture wallboards. There were no SPOs developed for these or other types of communication systems. As described above, no more than 18 individuals were provided AAC of any kind. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** There was no evidence of any SPOs related to communication with measurable goals or objectives and routine documentation to report progress developed by the SLPs. **Standard: For persons receiving behavioral supports or interventions, the Facility had a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP.** There was no policy or assessment/screening to identify those who received behavioral supports and interventions, such as a BSP, and would benefit from AAC or other communication-related interventions. A comment dated 12/6/10 in the POI reported that Mary Mooney, MA, CCC-SLP, was in the process of developing a screening and assessment tool that addressed key information needed to determine whether an individual would benefit from AAC. It was planned that this would drive the process independent of the annual PSP. It was reported that AAC assessments had been conducted as a part of the annual updates since September 2010. As stated above, most of the updates reviewed were not acceptable as comprehensive assessments and the AAC portion was inadequate. **Standard: Communication programs were integrated into the BSP as indicated.**	

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		In the assessments reviewed, for those completed after 9/1/10, there was a section that identified the target behaviors in the PBSP and passed judgment on the communication aspects of the strategies included in the plan (Individual #74, Individual #81, Individual #23, Individual #132, Individual #110, Individual #78, Individual #39, Individual #50 and Individual #15). There were 14 others included in the sample listed with PBSPs whose assessments did not address communication as it related to behavior concerns. Ten of these were identified as nonverbal and the other four, though listed as verbal, presented with concerns related to receptive and expressive language. There was little evidence that there had been actual collaboration between psychology and the SLPs in the development of PBSPs or in the development of skill acquisition plans to address individual needs as they related to communication. There was no evidence of integration of communication programs into the PBSP likely because there were few if any communication programs in place. During the previous review, it was reported that a meeting was held with the Director of Psychology on 6/22/10 to discuss integration of communication issues with behavioral assessments and the development of PBSPs. In addition, at that time, it was also reported that a section was added to the Communications Skills Update entitled "Communication Strategies and the Behavioral Support Plan." This was reported to have been implemented as recently as 6/23/10, weeks prior to the previous onsite review by the monitoring team. It was reported in the current POI to have been implemented on 9/1/10. The assessments reviewed that had been completed after this date included this new section. While this was a step, it was far from actual integration of assessment, supports, and services to address communication deficits as they relate to behavioral concerns. By report, individuals who had a BSP were monitored four times a year for AAC per the POI. **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 was no Master Plan used at EPSSLC though, per the POI, it was in development and still incomplete. The plan was to prioritize those individuals who would most benefit from AAC devices or equipment. There was no facility policy that outlined the communication assessment schedule, guidelines to prioritize assessments, or established specific staff responsibilities.	

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R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Standard: The PSP contained information regarding how the person communicated and strategies staff may utilize to enhance communication.** The PSPs offered very limited descriptions of how an individual communicated with others. In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to communicate were also very limited or non-existent. Some examples included: • Individual #46: "Does not speak. She uses facial expressions and vocalizations to communicate. Individual #46 is legally blind. Has a communication book, see for ways of interacting with her." There was no additional information related to communication in the PSP dated 10/7/10. • Individual #39: "Verbal communicator who comprehends basic directions and simple conversation. Has a communication book, see for ways of interacting with him." There was no mention in the PSP that he showed a preference for using sign language as reported in his Communication Skills Update on 5/29/10. There was no additional information related to communication in the PSP dated 5/19/10. There was no PSP addendum to address the findings of the AAC Assessment completed on 8/3/10. • Individual #110: She "is mostly non-verbal; she communicates through sounds and leading behaviors. Has useful vision by behavior and does not perceive auditory stimuli as meaningful." There was no additional information related to communication in the PSP dated 11/2/10. Though the POI indicated that the Communication Strategies for Optimal Communication were to be integrated into the PNMP, there was very little evidence of this in the PSPs dated after 9/1/10. As reported above, many of the PSPs submitted as part of the sample were marked as drafts and were incomplete, though they were dated in October 2010 and November 2010. For example, there was no evidence of these strategies in PSPs reviewed for Individual #15 (11/1/10), Individual #58 (10/14/10), Individual #110 (11/2/10), Individual #74 (10/19/10), Individual #81 (11/3/10), Individual #114 (11/9/10), Individual #23 (10/21/10), and Individual #46 (10/7/10). In the case of Individual #125, the strategies were included in a copy of the PNMP under the General Discussion Record. There was no documentation of any discussion of the plan by the PST, however. There was no evidence that the strategies were integrated into the action plans, though this PSP was marked as a draft and appeared to be incomplete as submitted. There was discussion that the SLP was to develop an Action Plan to teach Individual #125 to use an environmental control device and	Noncompliance

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		communication devices. There was no evidence that this was in place, however. He was listed in the spreadsheet with a Hip Talker device though there was indication in his Communication Update on 10/15/20 that this was not appropriate. It was indicated that he would benefit from a system that would use tangible objects, but this was not listed as a recommendation and was not mentioned in his PSP. In Individual #93's PSP dated 10/6/10, there was documentation of "discussion of non-priority needs" in which it was recorded that the QMRP had referred Individual #93 to Speech though the reason was not clearly documented. Under the discussion, there was reference that the PST discussed that she had not learned to use her communication book and that the SLP should create a program to address this. Further it was stated that her book should be updated to include pictures of items and activities that were important to her. While this was an important discussion, it was of great concern that a communication book had ever been issued for Individual #93's use that did not include items and activities that were important to her. In Action Plan #2, "Increase Individual #93's social skills," there was a step identified to "implement DCS as well as family members' use of communication book when interacting with Individual #93." There were no SPOs developed to provide skill acquisition opportunities for Individual #93, but rather outlined staff responsibilities only. There was no evidence of staff training planned to address use of the communication book. The SPOs developed for skill acquisition included: (1) she would learn to identify a store from one of two community resources via eye gaze (2) she would be assisted to select an item that she would like to purchase via eye gaze, and (3) she would learn to identify a dollar bill from one of two objects through eye gaze with gestured assistance and (4) she would learn to choose her daily attire from one of two choices with gestured assistance. There was no mention of the communication book or any other communication system for use in these programs. Individual #114 was listed with a talking photo album in the spreadsheet submitted, but this was not even mentioned in his Communication Skills Update on 10/19/10. It was listed as assistive equipment in the PNMP content under the General Discussion Record, but its use and how it would be integrated throughout his day were not even mentioned anywhere in the PSP. **Standard: AAC devices were portable and functional in a variety of settings.** There were so few AAC devices in use at the time of this review it was not possible to actually evaluate this element. There continued to be instructions that specific devices should not be used during meals, yet there were no alternative systems available for use beyond the Communication Book. Some examples included Individual #183, Individual #58, Individual #21, Individual #63, Individual #105, and Individual #92.	

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		Communication books or other systems were not noted to be in use during mealtimes in any of the homes observed. A schedule for use of devices continued to persist for a few individuals, including Individual #189 and Individual #11, clearly limiting portability and functionality of their devices (talking photo albums). There were a number of picture wallboards that were for community use which obviously were not portable and, as such, would not necessarily be functional for a number of users. **Standard: Communication programs and AAC devices were individualized and meaningful to the individual.** There was limited discussion of the settings observed or timeframes and methods used to assess individuals in the Communication Skills Updates. As described above, many of the strategies identified for use by staff were not individualized but were merely duplicated. In most cases, the selection of a system was not well justified in the assessment, particularly as it related to the Communication Books and Picture Wallboards. The standard paragraph for the AAC section of the Communication Updates was as follows: > There is a <u>Communication Dictionary</u> that has been developed which includes the words, communicative behaviors, and a specific repertoire for extra-linguistic communication used by [Individual]. Staff and family members should read the Communication Dictionary 2010 so that they can be aware of the specifics of how [Individual] communicates in various daily situations. [Individual] can benefit from the use of an Augmentative Communication Picture Book that staff can use with him to show him pictures or icons of items to be selected from. Staff can also use the book to show [Individual] pictures symbolizing upcoming events. Also the Communication Picture Wallboards (CPWs) installed in cottage [home] should be used by staff with [Individual]. They should encourage [Individual] to have the opportunity to choose types of clothing, foods, and condiments at meals by pointing to the various picture choices. Furthermore, staff should be alert for instances where [Individual] independently points at CPW pictures. He may attempt by pointing (at the CPWs) to actively communicate his needs, emotions, or convey his physical symptoms concerning his body (such as being tired, being in pain, injuries etc.) This paragraph was the sole extent of AAC assessment for at least 20 individuals (59%) of the sample records reviewed. Each was completed by Mr. Kielb. Again, very few individuals had been provided with any communication supports and services beyond the routine communication books and picture wallboards.	

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		It was reported that the speech staff had additional systems (other than wallboards) ready for use, yet they had not yet been installed. The current POI stated that "efforts are being made as of 9/1/10 to present a wider variety of augmentative devices and an introduction of augmentative devices in common areas for all individuals to use as needed/desired. They have already been shipped to the facility and are in the Speech Pathology Department and will be installed pending permission from residential/workshop/active treatment rooms." At the time of the previous review, a number of common devices were reported to be on order for use in the homes and workshops." It was of great concern that, if indeed these community devices were needed, that they were still not yet made available since the review in July 2010. There was no reference to a need for these devices in the assessments for individuals reviewed by the monitoring team. It was encouraging that, in a few assessments by Ms. Mooney and Ms. Puentes-Polo, that functional use, as well as size and type of icons in the Communication Books, were reviewed and, in some cases, the books were discontinued because they did not meet the individuals' needs due to vision or lack of meaning of icons or pictures (Individual #58, Individual #78, Individual #125, Individual #114 and Individual #4). The communication books continued, however, to be the only 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. In the case of Individual #93, her PST requested that the book be modified to reflect items and activities that were meaningful to her and that she participate in training to learn to use the book. Unfortunately, this had not been identified by Mr. Kielb in the annual assessment. There was no evidence that the modifications and SPO were implemented for her, however, despite this PST request. Generally, actual efficacy of use or the icons/pictures included were not assessed, but rather the book was automatically recommended for continuation for another year. The absence of individualized formal training regarding communication and language was a serious problem at EPSSLC. Similar comments regarding this are also included in sections F, S, and T of this report. **Standard: Staff were trained in the use of the AAC.** Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occur in order to promote communication skill acquisition. There were few if any formal	

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		communication programs. Staff continued to receive a one hour training related to AAC and communication in new employee orientation. By report, there was a half hour course that was mandatory for all employees to take on an annual basis related to communication. Additionally, it was reported that there were informal "practice" sessions conducted by the PNMPCs, but there was no documentation or evidence of this. There was no evidence that staff received individual-specific training related to the Strategies for Optimal Communication identified in the assessments. The POI identified that greater use of the PNMPCS and speech technicians was needed with validation by SLPs. There appeared to be some confusion related to competency-based training and validation of monitors. Direct support staff, PNMPCs, and speech technicians should be trained to competency based on a prescribed set of knowledge and skills necessary to perform a particular task or implement a communication program. Competency is assessed based on the return demonstration of the skill(s) by the trainee as observed and documented by the trainer. Validation pertains to the routine validation or co-monitoring by the SLP and the monitors to ensure inter-rater reliability and validity with the elements monitored. This validation occurs after the monitors have been trained to competency. Each process should be well-documented. The SLPs indicated that they had not documented the "competency-based" training they had provided to the PNMPCs or technicians related to communication. The POI reported that additional training of PNMPCs, speech technicians, and direct support professionals was needed. There was no plan in place to increase the training provided to direct support staff by the experts in communication (the SLPs), but rather that would be generally delegated to the technicians and PNMPCs, as needed. The POI reported that there were insufficient numbers of PNMPCs and RTT3s. There were no communication programs provided to the individuals in the sample reviewed and no evidence of individual-specific staff training. Direct support staff were not observed using the Communication Books with anyone (with one exception), though they were often opened in front of the individual. One staff was discussing each of the pictures with the individual as the monitoring team was observing, but did not create any opportunities for reciprocal interactions or social exchange. Use of the books was not integrated into other training provided. Most staff recalled receiving some training related to the books some time ago. These staff were not familiar with the Strategies for Optimal Communication for the individuals they supported. In the case of Individual #92, there was a training summary submitted related to use of a light that was installed for her use to alert staff that she needed assistance. There were no staff signatures on the inservice sheet submitted, so it was not known if the inservice had actually been provided to staff. There were no instructional plans for AAC use submitted in the sample records reviewed.	

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		Standard: Communication strategies/devices were implemented and used. In some cases, it was noted that the Communication Book or other device was not used by the individual (Individual #58, Individual #114 and Individual #125). It was of great concern that this had not been identified and addressed sooner, but rather the clinicians waited until the annual assessment to learn that the system in place was not effective. Skill acquisition training was not typically a consideration as there was only one SPO submitted in the sample records reviewed (Individual #92). A new system of monitoring had been implemented and it was anticipated by staff that problems with an existing system would be identified quickly with a timely remedy. Much of the interaction observed by the monitoring team was specific to a task with little other interactions that were meaningful, such as during a meal. Many of the programs implemented by direct support staff were not appropriate to the individuals observed and the communication methods used were awkward at best with likely limitations in meaning and function to the individual. For example, Individual #67 was observed during programming in which she was to identify the “dirty” gown from two pictures in a book. Staff reported that this was done because she could not distinguish between her dirty or clean gowns. It was difficult to see this in the picture and it was unclear why this program did not utilize actual clothing items. Assistance from the SLP, with regard to a program of this nature would be useful to provide better structure and functional meaning. In other cases, direct support staff were observed teaching money management to a group of individuals with significant physical challenges and obvious communication needs. They were to learn to recognize bills and coins from oversized pictures of these items. There was no system for the individual to demonstrate understanding of the task or information being taught. The task was not likely meaningful to those individuals in the group and the time could have been better spent involved in more functional activities to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology. Even the limited strategies identified in the communication skills assessments were not implemented in this setting. **Standard: General AAC devices were available in common areas.** A number of community picture wallboards were available in the homes; general devices were limited to these. As described above, there had been some additional devices (the POI described these as 20 voice output devices) obtained as long ago as August 2010, but they had yet to be installed and, thus, were not available for use. A number of the wallboards were seen by the monitoring team, but no examples of their use were observed. These non-portable devices may be useful as a backup or extra system for	

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		individuals, but should not be used as a primary augmentative or alternative means of communication for an individual. Again, none of these were observed in use during the onsite review by the monitoring team.	
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.	**Standard: A 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.** Draft policies were developed on 12/3/10 that included AAC Monitoring and an AAC Assessment Policy. This policy was not finalized and was not submitted with the document request information. A monitoring schedule was developed on 12/2/10 that included validation checks of the RTT-4s and RTT-3s by the SLPs. Individuals with PBSPs or who had AAC would be monitored four times a year. Others were monitored two times a year. One month prior to the PSP, the monitor and SLP were to monitor together to validate the competency and validity of the monitoring conducted by the technicians. Per the POI, a more in-depth AAC assessment would also be completed at that time. The POI identified two distinct types of monitoring intending to ensure that AAC or communication systems were implemented effectively. One addressed AAC devices and the other addressed the Strategies for Optimal Communication. This monitoring was designed to include a section for follow-up and one to alert the SLPs that revisions were needed per the POI. These forms were newly implemented (October 2010) since the previous review. There were 30 forms submitted for the Strategies for Optimal Communication monitoring and 30 forms for AAC monitoring. All were completed during the month of November 2010. There were 18 forms completed by the part-time speech technician and 24 by the fulltime speech technician covering 31 individuals. Findings of the AAC monitoring: • There were only seven out of 30 individuals identified as familiar with their device. There were 19 out of 30 individuals identified as unfamiliar with their device. The others could not be determined from the form (four out of 30). • Staff were unfamiliar with the device in three out of 30 cases. • In 14 out of 30 cases, other issues were identified by the monitor including missing instruction sheets, device not in use, individual's lack of interest, individual did not comprehend, individual throws his Communication Book, book not functional, and staff did not acknowledge training related to AAC. • In one of 30 cases, a referral was made to the SLP (Individual #3) due to lack of functionality of book, and staff had requested that the unnecessary pictures be removed and that more pictures that applied to him added. • In seven out of 30 cases, the findings were not reported in the AAC Monitoring	Noncompliance

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		Database to allow follow-up on concerns and analysis of results. It was not possible to determine the frequency of monitoring as the schedule or database was not submitted. No analysis of monitoring results was submitted as requested. Findings of the Strategies for Optimal Communication monitoring: • In 25 out of 30 cases, the individuals did not have these strategies. It was not clear why the monitoring was conducted for these individuals. • In 0 out of 30 cases, a referral was made to SLP or other professional, though in one case this was stated under findings documented in the AAC Monitoring Database for Individual #37. • In 11 out of 30 cases, the findings were not reported in the AAC Monitoring Database to allow follow-up on concerns and analysis of results. The comments and findings of the monitors suggested that they were insufficiently trained and/or that they were being expected to assess effectiveness of the AAC device or strategies that would be out of their scope as paraprofessionals. The SLPs should have routine and frequent responsibilities to monitor communication programs beyond the annual assessment or requests and referrals. Significantly more training related to what to look for and how to fill out the forms was indicated for the speech technicians. The current data would not yield meaningful information to shape training needs and track implementation of communication programs and AAC devices. The forms were complex and the elements were very broad in some cases and did not lend well to a yes or no answer. Significant text entries would either be lost or if entered would not be well utilized or functional in the database format. **Standard: Monitoring covered the use of the AAC during all aspects of the person's daily life in and outside of the home.** Monitoring of AAC was conducted in the homes rather than across settings, per the monitoring sheets submitted. **Standard: Validation checks were built into the monitoring process and conducted by the plan's author.** A system to validate the continued competency of monitors at EPSSLC was being developed but the current competency of the monitors reflected a need for additional competency-based training and modeling or partnering SLPs and technicians. Further assessment of this element will be necessary in future reviews.	

Recommendations:

1. A Master Plan should be developed and made public in order that PSTs understand how and why individuals were prioritized, and also know what to expect.

2. Speech staffing must be examined to ensure that clinicians with sufficient experience in the assessment and design of communication plans for individuals with developmental disabilities are consistently available. EPSSLC may want to consider the use of Speech Assistants to assist with the implementation of communication programs (SPOs) and for staff training and monitoring.

3. Assessments must provide a clearly stated and thorough rationale as to why or why not AAC is determined to be appropriate for an individual. Currently, the standard was to continue the current system of communication books, dictionaries and picture wallboards, rather than explore other options. In addition, greater specificity is needed to describe the clinical reasoning process used by the therapist to select a particular device. These are key elements to a comprehensive assessment that meet generally accepted professional standards of care.

4. For those receiving direct services, well defined, measurable, meaningful, and functional goals or outcomes must be clearly stated with indices of progress reviewed no less than monthly. Modifications to intervention plans must be made when lack of progress is noted. Ensure all of these are integrated into the PSP process.

5. Examine methods to ensure actual integration and collaboration to address the communication needs of those with behavioral concerns. The current method of referring to the PBSP will not meet the intent of this provision.

6. Consider implementation of more individualized AAC systems and greater variation in community systems because the majority of the existing systems for individuals were limited to community systems. It is understood that this is an excellent beginning. This is also a more manageable approach given the staffing limitations, however, recommendations must be based on identified need and not modified by the knowledge that implementation of an alternate approach could be difficult.

7. There is a significant need to develop programs to address increasing or expanding language skills, ability to make requests and choices, and other basic communication skills. Formal programming is indicated for a number of individuals. Speech staff should also model more informal ways to promote interaction and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs.

8. Consider expanding the NEO training to move out beyond AAC, but rather also teach staff to understand how to be an effective communication partner. As AAC is developed, it then becomes a method much like speech, rather than a unique entity in which the functional purpose becomes lost on staff. When that happens, it loses meaning for them as well. It becomes a "task" and is not integrated into the individual's daily routine.

9. Many recommendations appeared to be left to the PST for the development and implementation of plans, even in the absence of sufficient staff training. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials, and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as training, modeling, and coaching for staff. 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. Communication goals can, and should, be addressed across the full gamut of

training objective programming.

10. Clarification of expectations for monitors related to the indicators on the PNMP Monitoring Sheet must be provided. Each element must be well defined. This is reinforced through competency-based training and validation.

11. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs.

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:** <u>Documents Reviewed</u>: o Personal Support Plans (PSPs) for: • Individual #1, Individual #79, Individual #109, Individual #14, Individual #43, Individual #61, Individual #18, Individual #10, Individual #99, Individual #132, Individual #100, Individual #89, Individual #103, Individual #172, Individual #90 o Specific Program Objectives (SPOs) for: • Individual #81, Individual #39, Individual #24, Individual #31, Individual #184, Individual #19, Individual #132, Individual #18, Individual #51, Individual #46, Individual #162, Individual #125, Individual #3 o Six months of SPO Progress Notes for: • Individual #14, Individual #61, Individual #18, Individual #109, Individual #99, Individual #43 o Quarterly reviews of SPO progress for: • Individual #88, Individual #161, Individual #30, Individual #115 o EPSSLC Plan of Improvement, dated 12/16/10 o List of individuals who attended public school (five individuals) o ARD/IEPs for Individual #132 and Individual #69 <u>Interviews and Meetings Held</u>: o Cynthia Martinez, Acting QMRP Coordinator o Janice Chowning, Active Treatment Coordinator o Valerie Grigg, Director of Behavioral Services o Alex Euzarraga, QMRP <u>Observations Conducted</u>: o Personal Focus Meeting • Staff Present: - Joseph Melero, QMRP; Phillip Bueno, RN case Manager; Marisela Franco, Associate Psychologist; Ruben Morales, Psychology Assistant; Clara Aguilera, OT; Susana Lopez, DCP • Individual Presented: - Individual #10 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), and • Implementation of behavior support plans
	Facility Self-Assessment: EPSSLC's Plan of Improvement (POI) indicated noncompliance for each item of this provision except S3. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's POI report, except for item S3. S3 is rated as being in noncompliance because, although there is evidence of some SPOs being based on assessment results, this process was not clearly documented for all specific program objectives (SPOs) reviewed, and it was not clear that SPOs were consistently implemented with integrity. Additionally, the POI indicated new training objectives had been developed that provided training opportunities in the community, however, the monitoring team did not find any evidence of training opportunities in the community. More detailed reasons for the discrepant evaluations are discussed below.
	Summary of Monitor's Assessment: This provision of the Settlement Agreement incorporates a wide variety of aspects of programming including 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. Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, there were some positive developments since the last review. These include: • The facility had begun to improve the incorporation and documentation of individual's needs and preferences into the development of SPOs • Psychologists were beginning to write SPOs for medical desensitization • Day programming had recently been modified to improve Individual engagement • Individual engagement scores for the facility had improved • DCPs had received training in the effective use of behavioral methodologies for the acquisition of skills • The acting QMRP coordinator appeared to have a good understanding of what needed to be done to achieve compliance with this provision of the Settlement Agreement

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of 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. Skill Acquisition Programming Skill acquisition plans at EPSSLC consisted of training objectives, referred to as specific program objectives (SPOs), which were written and monitored by three program developers. Program developers were supervised by QMRPs, and SPOs were implemented by direct care professionals (DCPs). Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures had just begun to be developed by the psychology department at the time of the onsite review and, therefore, no medical desensitization plans were available for review. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with desensitization plans, will be reviewed in more detail during future onsite visits. EPSSLC included replacement behaviors in each PBSP. There were, however, no descriptions of teaching conditions, and no specific teaching instructions (see K4). Replacement behavior training procedures should be incorporated into the general training objective methodology (i.e., written as SPOs), and conform to the standards of all skill acquisition programs listed below. The monitoring team found no skill acquisition programs targeting the enhancement or establishment of communication and language skills (see sections R and T). It is recommended that the facility establish communication SPOs for individuals with communication needs. Finally, 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. As discussed in the last report, an important component of an effective skill acquisition plans is that they should be based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, or psychological	Noncompliance

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		assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. Conversations with the QMRP coordinator indicated that the facility recently attempted to incorporate preferences and needs into the development of individual SPOs. The monitoring team did find some examples in the personal support plans (PSP) that SPOs were developed to address individual preferences and needs. For example: • Individual #1's PSP indicated that she enjoyed using her hands, and two of her self-care SPOs involved the use of her hands. • Individual #79's PSP identified a job as one of her needs, and an SPO was developed to teach her to fill out an employment application. For the majority of SPOs reviewed, however, the rationale for their selection was unclear. In fact, as discussed in provision T, many of the SPOs reviewed appeared to be nonfunctional. 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 As discussed in the last review, none of the SPOs reviewed included the use of relevant discriminative stimuli, a plan for maintenance and generalization of achieved skills, or specific consequences for incorrect responses.	

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		Finally, the training methodology for SPOs at EPSSLC was identical for all SPOs reviewed. It consisted of the training of one step of the task analysis at a time and the use of least-to-most prompting. Additionally, the training procedures were often very general. For example, the training method for Individual #39's self administration of medications was: 1. prompt him to wash his hands 2. encourage him to identify his blue capsule 3. praise him when correct This general approach likely contributed to the poor treatment integrity observed by the monitoring team (see S3). 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. The facility reported that they were continuing to inservice DCPs and program developers on the use effective skill acquisition procedures. 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. 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 cottage and day program is listed below. EPSSLC had made some efforts to improve individual engagement since the last review. For example, structured group activities were added to the day program. At prearranged intervals, individuals moved from one activity station to another. This model for enhancing engagement appeared very promising, but had been recently initiated and details of the activities were not completely resolved at the time of the onsite review. The monitoring team looks forward to seeing the activities in full operation at the next review.	

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		As discussed in the two previous onsite reviews, the monitoring team noted very few structured activities in the cottages. The DCPs in cottages 511 and 507, however, were making considerable efforts to engage all individuals in activities. Those activities, however, were all individual and included dated activities such as placing pegs in a board, putting together puzzles, and playing with Legos. Conversations with staff indicated that these were the same activities that they have been doing for years. The director of active treatment and day programming indicated that her department did not have staff to assist DCPs in developing and implementing group activities during the evening shift. The facility needs to work on individualizing and updating the activities scheduled, provide additional staff training, attempt some meaningful group activities, and actively manage individual engagement in the cottages during the evening shift. The average engagement level across the facility was 50%, a small increase over the activity level found during the last review (42%), and the baseline measure of engagement (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 EPSSLC, indicating that the engagement of the individuals at EPSSLC had considerable room to improve. It was good to see that the facility had initiated a methodology for capturing individual engagement. The monitoring team reviewed the facility's engagement data from December 2010. During the month, nine observations were recorded and the average percentage of engagement was 66. The variance between this level of engagement and that reported by the monitoring team may reflect the differences in the definition of engagement and/or the location of the measures. All nine of the facility's measures occurred during the day shifts, while the monitoring team's observation included both day programs and observations at each cottage during the evening shift. It is recommended that the facility expand the collection of engagement data to the evening shifts in the cottages. Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
A Dorm	1/4	2:4
B Dorm	2/9	2:9
B Dorm	0/8	2:8
Cottage 512	5/6	3:6
Cottage 509	1/4	2:4

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Cottage 509	2/5	1:5
Cottage 509	1/3	1:3
Cottage 508	2/5	1:5
Cottage 510	1/8	1:8
Cottage 511	3/4	2:4
Cottage 511	2/4	2:4
Cottage 512	1/4	0:4
Cottage 512	1/3	1:3
Cottage 513	1/4	1:4
Cottage 513	5 /7	2:7
Cottage 513	6/7	3:7
Cottage 507	5/7	3:7
Cottage 507	4/5	2:5
Cottage 506	4/4	3:4
Cottage 506	4/4	3:4
A Dorm	3/12	3:12
B Dorm	1/3	2:3
Vocational Workshop	18/18	5:18
Vocational Workshop	16 /18	5:18
Vocational Classroom	5/6	2:6
Vocational Classroom	2/10	3:10
Vocational Classroom	0/2	0:2
Vocational Classroom	1/4	2:4
Vocational Classroom	1/1	1:1
C Dorm	3/8	2:8
C Dorm	3/8	2:8

Educational Services

Five individuals living at EPSSLC were under age 22 and continued to attend public school programming provided by the local education agency, the El Paso Independent School District (EPISD). Four attended high school and one attended middle school. The monitoring team reviewed the ARD/IEPs for two of the individuals (Individual #132 and Individual #69) as well as spoke with the EPSSLC QMRP who had responsibility as liaison with the public school.

Overall, the positive relationship between EPSSLC and EPISD described in the previous monitoring report continued. At this time, only one QMRP interacted with the public school rather than the three who were doing so at the time of the previous onsite review.

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		This resulted in improved and consistent communication. The QMRP attended all ARD/IEP meetings and reported that he was an active participant and that his input and comments were invited by the school district. Moreover, he reported that he had brought other members of individual's PSTs to school meetings, such as the nurse, psychologist, and program developer. He said that he communicated regularly with the schoolteachers via the phone and email. One example was regular communication regarding any occurrences of seizures so that EPSSLC nursing and direct care staff had that information if a seizure had occurred during the school day. Further, he said that the students appeared to like going to school, especially Individual #132. The two ARD/IEPs reviewed showed a large number of instructional objectives that appeared to be relevant to the student's education. The monitoring team requested, but did not receive any reports regarding the progress of the students on their educational objectives. Further, the EPSSLC PSPs for three students were reviewed (Individual #132, Individual #38, and Individual #81). There was no indication in these three PSPs of any coordination or integration with the public school program, staff, or ARD/IEP.	
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.	EPSSLC conducted annual assessments of preference, strengths, skills, and needs. As discussed in S1, however, it was not consistently documented how this information impacted the selection of specific program objectives. Therefore, this item is rated as being in noncompliance. Additionally, while the PSP 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	Improvements are needed in the monitoring of SPO progress and outcomes before this item can be rated as being in substantial compliance. Program developers at EPSSLC summarized SPO data monthly and QMRPs presented	Noncompliance

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	and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	those data at quarterly meetings. The skill acquisition plans appeared practical and functional for some individuals (e.g., Individual #81 learning to obtain the necessary materials for his oral care), but nonfunctional for others (see section T). Additionally, as discussed in S1, it was unclear how or why many SPOs were chosen. Reviews of SPO data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., Individual #88's vocational SPO), but not for others (e.g., money skills, identification of traffic lights, and community awareness for Individual #115; self medication for Individual #30). The monitoring team was encouraged that some SPOs were modified based on the completion of goals (e.g., money management and personal hygiene for Individual #88), and due to the absence of progress (e.g., improving work skills for Individual #14). Other SPOs reviewed (e.g., money management, identification of traffic lights, and community awareness for Individual #115), however, indicated an absence of progress without a revision of the SPO. During the last onsite review, EPSSLC began to graph SPO data to improve the ability to evaluate the effectiveness of the SPOs. The use of graphing, however, was not being utilized at the time on the onsite review. The acting director of QMRPs assured the monitoring team that the graphing of SPO outcomes would soon be re-implemented. In addition to the graphing of individual SPO progress data, it is recommended that these graphed summaries be used to make data-based decisions concerning the continuation, discontinuation, or modification of the skill acquisition plan. The monitoring team observed the implementation of SPOs during day programming and in the cottages in the evening. For example: • The monitoring team observed DCPs implementing Individual #132's money skills SPO. Although the DCP enthusiastically conducted the training (and Individual #132 appeared to enjoy the interaction), the DCP simply gestured the boxes Individual #132 should mark. Individual #132 then proceeded to mark that box, and every other box on the paper. When asked about how the training procedure should occur, the DCP did not appear to understand that the purpose was to teach Individual #132 to mark the correct boxes independently. • Similarly Individual #19's teeth brushing SPO involved the DCP simply brushing Individual #19's teeth without allowing Individual #19 the opportunity to engage in the activity more independently. It is recommended that program developers or QMRPs regularly observe and collect SPO integrity data to ensure that SPOs are being implemented as intended. Additionally, SPO data sheets were reviewed in the cottages to evaluate if data were completed as scheduled. The monitoring team was encouraged that all of SPOs sampled were	

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		completed as scheduled.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at EPSSLC enjoyed various recreational activities in the community. It appeared that individuals were not provided with training in the community that addressed specific needs for services or preference. Therefore, this item was rated as being in noncompliance. As in the last two reviews, one individual at the facility worked four hours a week in the community at the time of the onsite review. Interviews with staff indicated that the primary reason for the absence of community employment was the economic recession. Although the Plan of Improvement indicated that EPSSLC had begun to develop SPOs that address needs for services and training in the community, the monitoring team did not find any documentation of training in the community beyond the one Individual discussed above. Subsequent reviews to EPSSLC will further evaluate the training individuals receive in the community in order to assess compliance with this provision item.	Noncompliance

Recommendations:

1. Medical and dental desensitization SPOs should be written by psychologists and provided to all individuals identified to need them.
2. Replacement behavior training procedures should be incorporated into the general training objective methodology (i.e., written as SPOs), and conform to the standards of all skill acquisition programs listed below.
3. The facility should establish communication SPOs for individuals with communication needs.
4. Habilitation therapists should establish SPOs for interventions with measureable goals and clear consistent reporting on progress that occurs within the PSP system as is done with all SPOs.
5. It is recommended that the facility more clearly document how SPOs are based on individual needs and preference.
6. SPOs should include the use of relevant discriminative stimuli, plans for the maintenance and generalization of acquired skills, and specific consequences for incorrect responses.
7. The facility should expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires.
8. The facility should focus on the training and monitoring of group Individual engagement in the cottages during evening hours.

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

10. It is recommended that a plan be developed to collect and graph integrity data to ensure that SPOs are conducted as written.

11. The facility should ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.

12. Document integration of the public school program, including the ARD/IEP, in the individual's PSP.

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 attachments (exhibits); this policy was re-labeled as the EPSSLC policy. o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010, July 2010 o DADS Obstacles Report for SSLCs, October 2010 o EPSSLC Organizational chart, not dated o EPSSLC policy list, two pages, not dated o List of typical meetings that occurred at EPSSLC o EPSSLC POI, December 2010 o EPSSLC Admission and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/3/11 o Position description: Admissions/Placement Coordinator and Post-move monitor o Weekly enrollment report, 11/19/10 and 12/30/10 o List of individuals who were referred for placement and had been placed since 7/1/10, dated 11/23/10 (two individuals, one of whom was placed since the last onsite review) o List of individuals who were referred for placement and had not yet been placed, dated 11/16/10 (nine individuals) o A document indicating that no individuals had themselves requested community placement o Community placement obstacles, dated 11/22/10 o Document stating that EPSSLC did not assess individuals for community placement o Document stating the no individuals had returned to EPSSLC after being placed in the community o Community Placement Report, dated 1/6/11 o Various lists and documents related to the provider fair "Summer of Discovery," 7/9/10 through 8/20/10 o Documents from MRA provider meeting: agenda for 10/28/10 and minutes from 8/26/10 meeting o Email and sign in sheets for training session on the new style CLDP, 11/5/10, conducted by previous APC o CLOIP tracking sheets for 9/10, 11/10, and 12/10 o Permanency Planning tracking sheet for 10/10 o CLOIP Worksheet for: • Individual #164, Individual #79, Individual #65, Individual #8, Individual #117, Individual #112, Individual #25, Individual #60, Individual #70, Individual #131, Individual #118, Individual #120, Individual #42, Individual #49, Individual #92, Individual #94 o Spreadsheet of individual's visits to community providers o Proposed revised CLDP format (blank) o Proposed new post move monitoring form

	○ Blank form listing required discharge reports ○ New Style PSPs for: • Individual #109, Individual #1, Individual #103, Individual #132, Individual #100, Individual #89, Individual #79, Individual #90, Individual #31 ○ Completed monitoring form of living options discussion section of annual PSP meeting for: • Individual #127, Individual #117, Individual #42, Individual #100, Individual #90 ○ Personal Focus Assessment for: • Individual #172 ○ CLDPs for: • Individual #164 ○ Post move monitoring checklists for: • Individual #124: 7-, 45- and 90-day checklists • Individual #150: 7-, 45- and 90-day checklists ○ Sign in sheets for training EPSSLC conducted for provider staff on dysphagia and food texture <u>Interviews and Meetings Held</u>: ○ Antonio Ochoa, Admissions and Placement Coordinator ○ Alice Villalobos, Post-Move Monitor ○ Jaime Monardes, Facility Director ○ Alex Euzarraga, Norma Padia, Santa Moore, QMRPs ○ Draco, Inc., community provider agency staff: Gisel Hita, program director, Michelle Cobarrubia, case manager, Minerva Torres, house manager, Robert Chapa, house staff member, Robert Chapa, house staff member ○ Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: ○ PSP Meeting for: • Individual #90, Individual #31 ○ PFA Meeting for: • Individual #172 ○ Community group home visit, post-move monitoring for • Individual #124 ○ Self-advocacy meeting ○ Many residences and day programs at EPSSLC
	Facility Self-Assessment: The facility's self-assessment, its POI, was revised and simplified compared to the POI presented during the previous onsite review. This was an improvement and should provide the admissions and placement department with guidance and direction. The POI was dated 12/16/10, that is, only two weeks before the

	onsite review. The monitoring team recommends that the department use the information provided in this section of the report to revise the content of this POI. Many comments, feedback, recommendations, and suggestions are provided below. It would make sense for the APC to use this report to guide him in setting forth a set of actions to work towards achieving substantial compliance with this provision. The monitoring team believes that the current content of the POI (comments for each provision item, and action plans) indicates actions that will likely be insufficient to achieve substantial compliance. The POI indicated noncompliance with all provision items except for four. The monitoring team did not agree with these four self-ratings of substantial compliance. One was for T1e regarding the identification of essential and nonessential supports. As noted in previous reports as well as in this report below, the identification of these supports was one of the most serious problems with the facility's practices regarding most integrated settings. Another item self-rated as in substantial compliance was T2a regarding post move monitoring. As noted in the report below, the facility had a competent post move monitor. The need for better delineation of essential and nonessential supports, including good definitions, descriptions of evidence for verification, and criteria were not in place. More work will need to be done by the PSTs, APC, and PMM on the essential and nonessential supports. The other two self-rated items were rated as being in noncompliance by the monitoring team due to the need for changes in documentation. The POI did not indicate that the facility looked at any of the PSPs, LODs, optimistic vision statements, CLDPs, or post-move monitoring forms to make a determination of their own substantial compliance or noncompliance. The facility will need to engage in specific activities to self-assess the status of its performance for this provision and all of its components. This will probably involve monitoring, sampling, and providing feedback to PSTs, post-move monitors, and facility management. The POI can certainly provide guidance. The monitoring team's review was based upon observation, interview, and review of a sample of documents. The facility will need to do much of the same in order to conduct an adequate self-assessment. The APC's presentation book contained a lot of relevant information, including an indication that he had recently begun to implement monitoring checklists for section T.
	Summary of Monitor's Assessment: EPSSLC had not made much progress in meeting the items of this provision of the Settlement Agreement. This was due to a number of reasons, including the appointment of a new Admissions and Placement Coordinator less than two months before this onsite review, the status of only a few individuals being active in the referral and placement process, and post move monitoring processes that were in the process of being updated. Areas in which little or no progress occurred included the number of individuals placed and referred, the incorporation of professionals' opinions into the decision to refer, identification and addressing of obstacles to placement, identification of relevant objectives in the PSP, clear definitions of supports essential to the individual's transition, and education of individuals and LARs about community options.

	Some progress was seen in the PSP process. More individualized and participatory discussion occurred at the PSP meetings observed by the monitoring team compared to the PSP meetings observed during the previous onsite review. This provision, however, is rated as being in noncompliance due to the additional tasks and activities that are required by the provision, and improvements that are required to occur regarding a number of facility practices, 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. The number of individuals placed in the community was low, only one placement occurred since the last onsite review. One individual was scheduled to move within the upcoming month and others were on the referral list, some for more than six months. On the other hand, two individuals were referred recently, including one during a PSP meeting observed by the monitoring team. The facility needed to do more tracking of individuals in relation to obstacles to referral. For example, the facility did not have a list of individuals for whom LAR preference was the only reason for he or she not being referred for placement. EPSSLC continued to engage in a number of activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy. EPSSLC, however, should consider ways of assessing the effects of these activities and making improvements. Outcomes of the provider Summer of Discovery activities and the CLOIP activities should be determined and the effectiveness of these activities assessed. Further, as noted below, more work should be done on the system of community tours, and the self-advocacy group could be used as an opportunity to educate individuals about community placement. The CLDP process was also being revised. Comments are provided regarding the proposed new CLDP and post-move monitoring forms and procedures. A continuing problem was the absence of the inclusion of individualized and meaningful essential and nonessential supports within the CLDP. The ability of PSTs to play a more active role was needed; examples are provided. Post move monitoring was occurring. The post move monitor conducted visits to both the day program and residence of each individual for each of the three required post move monitorings. Due to the few placements completed by EPSSLC, few post move monitoring visits were required. All were done according to schedule and using the required form. There continued, however, to be a need for more detailed descriptions of essential and nonessential supports, so that they could be observed and so that the post-move monitor would know what was required to indicate evidence of the presence of the support. A visit by the monitoring team to a home for a 90-day post-move monitoring visit occurred. Important information was obtained and the post move monitor conducted the visit in a professional and organized manner. Improvements, however, were needed to ensure that adequate evidence was observed to indicate the presence of each support.

	The new post move monitoring form was used for this 90-day visit observed by the monitoring team. A number of problems with this new form were identified by the monitoring team. These problems led to there being less information now being reported by the post move monitor compared to what was reported on the old form. Specific comments and suggestions are provided below. Specific quality assurance procedures were not in place (see section E above), however, admissions and placement staff, as well as one QA staff member, had recently begun to complete monitoring tools regarding some of their work. Modifications are recommended for improvements to the CLDP, the CLDP process, determination of essential and nonessential supports, and contents of the community placement report.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	EPSSLC had not made much progress in meeting the items of this provision of the Settlement Agreement. This was due to a number of reasons, including the appointment of a new Admissions and Placement Coordinator, the status of only a few individuals being active in the referral and placement process, and post move monitoring processes that were in the process of being updated. Thus, at the time of this onsite review, much of what was observed during the previous onsite review remained the same, and much of what was written in the previous EPSSLC monitoring report remained relevant (with some exceptions as noted below). Some of the areas in which no progress was observed included: • incorporation of professionals' determinations into the referral process • determination of needed supports • identification of obstacles • development of the CLDP • identification of essential and nonessential supports • objective determination of the presence or absence of essential and nonessential supports following community placement. Nevertheless, EPSSLC and the state engaged in some activities to encourage and assist individuals to move to the most integrated setting. These activities 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.	Noncompliance

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		The monitoring team, as noted above, learned about many changes that were in the works at both the facility and state levels regarding PSP processes, CLDP contents, determination of evaluation of essential and nonessential supports, and training of all facility staff and departments regarding the community referral and placement process. The new PSP process was observed in action during the onsite review, and a draft of a revised CLDP format was presented to the monitoring team for review. These two new processes are discussed below in this section of the report.
		
		Referral and placement activities were overseen by Antonio Ochoa, the Admissions and Placement Coordinator (APC). Mr. Ochoa had only recently been appointed to the position (in November 2010) following the retirement of the previous APC. Although new to this position, he had more than 20 years experience at the facility in a variety of positions, including as facility director. Even so, he was only at the beginning of learning the details and minutiae of the admissions and placement process, CLDPs, post-move monitoring, and the other aspects of section T of the Settlement Agreement. He had received some orientation to this new position by spending three days with the APC at the Lubbock SSLC. He reported having read the details of the previous monitoring report and was looking forward to additional training by DADS. The monitoring team also recommends that the APC read section T of the other monitoring reports completed by this monitoring team.
		
		The APC position continued to be assisted by the post-move monitor (PMM), Alice Villalobos. Ms. Villalobos remained in this role since the last onsite review. She had approximately five years of experience at EPSSLC and was very knowledgeable about the section T requirements, the CLDP process, and post-move monitoring.
		
		The number of individuals in the referral process at EPSSLC was low:
		• One community placement occurred since the last onsite review. This compares to three placements that had occurred and were reviewed during the previous onsite review six months ago.
		• Ten individuals were on the active referral list given to the monitoring team, including one referral that occurred during the week of the onsite review. This was an increase from the previous onsite review during which only four individuals were actively referred. Of these four, one had moved to the community and the other three remained in the referral process.
		• Of the 10 current referrals:
		    • One was scheduled to move within the month and the CLDP meeting was held during the week of the onsite review (Individual #164).
		    o One had identified a provider and plans were being made for her to live in a group home with one of the individuals who moved from EPSSLC in	

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		2010 (Individual #130). o Four individuals were looking at, and considering, providers (Individual #14, Individual #68, Individual #54, Individual #55). o Four other referrals were new and little activity had yet occurred (Individual #110, Individual #85, Individual #132, Individual #31). Family members of some of these individuals were reported to be in disagreement with the referral, but because they were not appointed as LAR, the facility was moving ahead with the referral. The facility, however, was attempting to work with each individual's family members. This is an area where the facility needs to be very thoughtful and develop a procedure to ensure that family involvement is supported. A recent success doing so was noted for Individual #164. His initial referral occurred more than a year ago. Placement was due to occur in February 2011. The delay was due to family disagreement due in large part to the family's lack of knowledge of community service programming which was only recently corrected and resolved. Family members were in disagreement with the referrals of four of the other currently referred individuals, according to the APC. The APC should develop an individualized plan to work with each of these cases so that errors do not occur. For example, without proper oversight and planning the following happened: no management or clinical staff went to accompany family members when they met the individual (their brother) and his direct care staff on visits to community provider group homes. It is likely that management or clinical staff would be able to answer questions about community transition and placement that most direct care staff could not. The facility indicated that no individuals themselves requested to move. This appeared to the monitoring team to be incorrect. For example, a number of individuals at the self-advocacy meeting expressed a desire to move. The facility did not maintain a list of individuals for whom LAR preference was the only reason for a referral not occurring. This information should be gathered and managed. No referrals had been rescinded since the last onsite review. No individuals had returned to EPSSLC after being placed in the community. This provision item also requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. It appeared to the monitoring team that the opinions of the professionals on the PST were not adequately incorporated into discussion, documentation, and decision-making as required. This was based on two aspects of the monitoring team's review, as follows:	

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		• Sixteen CLOIP worksheets for November and December 2010 were reviewed. Overall, they were documents that briefly described the interactions between the MRA CLOIP worker and the individual and the individual's LAR and/or primary family member contact. The CLOIP worksheets also included the MRA CLOIP worker's opinion regarding placement. Of the 16 individuals whose worksheets were reviewed, one was currently on the referral list. At least six of the other 15 individuals appeared to be reasonable candidates for referral, however, none were referred. It was possible that these were examples of individuals whom the team might have referred.
		• A statement at the end of the PSP narrative attempted to summarize the PST's decision regarding most integrated setting and referral. These were typically one or two sentences. It provided insufficient detail regarding the opinions of professionals, and led the monitoring team to assume that the professionals did not provide their opinion on this important matter.
		  o "PST agreed with Individual #79's mother and determined that EPSSLC is the most appropriate and safe place for Individual #79."
		  o "The team is in agreement with [parent] that the current home is the optimal living option for Individual #89 at this time."
		  o "The team is in agreement that Individual #100's current home is the optimal living option for him at this time."
		
		Perhaps the new style PSP may set the occasion for the incorporation of professional's determinations. For example, at the PSP meeting for Individual #31, professionals challenged whether there were really any obstacles to her placement. The discussion quickly progressed from giving her some opportunities to visit a community group home to making a full referral for placement. The facility should support these types of discussions, ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. This provision item allows (and calls for) professional determination as separate from both the preference of the LAR and the opinion of the PST as a whole.
		
		As noted in the previous monitoring report, the monitoring team found that EPSSLC senior management did not receive regular reports and updates regarding 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. One way to do so is to have referral information be part of the facility's quality assurance program and part of the comprehensive list of data collected at the facility (see section E1 above).
		
		The APC kept a Weekly Enrollment report. It listed the number of individuals in each of the 11 homes and six other types of information (i.e., scheduled community placements,	

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		admissions, and transfers; current community referrals; new referrals for admission; and inquiries for admission). Although this report was sent to management staff, it did not appear that anything was done with it. Furthermore, the report did not give any detail on the status of the active referrals. The monitoring team suggested that the APC contact the Lufkin SSLC APC. Her weekly written report and weekly presentation kept the Lufkin SSLC management staff more fully informed and more engaged in the referral process than the current report did so for the EPSSLC management staff. 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.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	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 the need for improved practices as discussed in all of the following subsections of this provision T1b. Upcoming changes in the state and facility policies were reportedly being designed to improve current practices regarding most integrated setting practices so that they would be more likely to be in substantial compliance with this provision item. 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. All of the monitoring team's comments from the previous monitoring report remained the same for this review and are repeated below. That is: (a) 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. (b) 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. (c) 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	Noncompliance

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		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 state's policy. The APC reported that EPSSLC had adopted the state policy and was working under the policy. The state policy was available at the facility and had been re-labeled as a facility policy. During onsite reviews at other facilities over the previous few months, the monitoring team learned that 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 consider whether any additional facility-specific policies could be helpful to the operation of its referral and placement services. It appeared that the facility was planning to do so based on one of the comments in the POI. If so, these policies should be reviewed and approved by the DADS central office. 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 changes.	
	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	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 new statewide policies and procedures were being implemented at EPSSLC regarding the PSP process. These policies and procedures were recently taught to the facility's QMRPs and the new procedures were put into place in mid-November 2010. All three of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. These were implemented under the new PSP format. One QMRP led two of the meetings. He had conducted approximately a half-dozen PSPs	Noncompliance

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	integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	using the new style format. The third meeting was led by a second QMRP. It was her first time using the new style format. The monitoring team appreciated having the opportunity to observe these meetings. It would be helpful, however, if more annual PSP meetings were conducted during the week of the onsite review and if these meetings could be led by a wider variety of QMRPs. In this way, the monitoring team's observations would be more representative of the overall practices at the facility. The monitoring team understands that scheduling is limited by a variety of factors, such as room availability, preferences of family members and LARs, and ICFMR required timelines. Nevertheless, if there is any flexibility that allows for more annual PSP meetings to be scheduled to occur during the week of the onsite review, it would be greatly appreciated by the monitoring team. In addition to attending the three PSP meetings, nine new-style PSP documents were reviewed (listed in the Documents Reviewed list at the beginning of this section of the report). The total sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. The PSPs represented all of those that had occurred since 11/15/10 and for which the completed PSP document was available for review. The monitoring team only reviewed these PSPs for the purpose of monitoring this provision item because the old-style PSPs had been completely replaced by these new style PSPs. These nine PSPs included two of the three PSP meetings that occurred during the week of the onsite review. The monitoring team appreciates that the facility sent these for inclusion in this report shortly after the conclusion of the week of the onsite review. <u>Protections, Services, and Supports</u> The new-style PSP for each individual noted a variety of preferences, needs, required supports, and action plans (i.e., service and training 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 section titled "Integrated Discussion - Optimistic Living Vision." The discussion about the ideal optimistic vision should focus on 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, and skill development and maintenance), and quality of life activities, such as leisure and recreation activities. The optimistic vision should not merely be a listing of the individual's preferred items. Nor should it merely be a listing of the supports needed by the individual. That being said, the EPSSLC documents, the meetings that were observed, and conversations with some of the QMRPs indicated that the facility was eager to achieve	

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		this type of integrated discussion. The monitoring team expects that the QMRPs, with proper training and support, should be able to accomplish this. Each written PSP began with a listing of the individual's preferences. This list came from a meeting held a couple of weeks prior to the annual PSP meeting called the PFA (Personal Focus Assessment). Below this listing was a short paragraph describing which of these preferences was most important. Following this was a heading "Integrated Discussion – Optimistic Living Vision" followed by standardized sections: awareness of community options, preferences of individual and LAR, obstacles, needed supports, and a statement about the most integrated setting and the PST's determination as to whether or not to make a referral for community placement. All of the PSPs were short, up to four pages, plus the list of action plans and the signature attendance page. The monitoring team suggests that a section be added to the form regarding relevant history. More detail should be included regarding the individual's needed supports and services. The three PSP meetings observed by the monitoring team did not follow the format of the written PSP. As indicated above, this was by design and, as a result, they were more free-flowing, especially given the verbal nature and participation of both individuals observed. The written documents, however, did not accurately reflect the likely breadth (or brevity) of the discussion in each of the areas of the written report. Although the written PSP needs to follow a structured format, the resulting document needs to reflect the level and intensity of discussion that occurred during the meeting. The monitoring team also looked at the skills chosen by the PSTs to be taught in a formal structured manner using training objectives (called SPOs). Across the nine new style PSPs reviewed, the number of skill training objectives ranged from five to nine per individual. This was a relatively small number of training objectives per individual, considering that at least two of each individual's objectives were the state-required self-administration of medication and money management related objectives. Furthermore, • Many of the skills chosen were nonfunctional, especially ones about identifying a picture of money (bills or coins), identifying other types of pictures (e.g., of a nurse), and looking at a poster of handwashing. Every individual had two or three of these types of objectives. • At the same time, communication and language skills were never addressed as a skill to be taught in a formal manner. Instead, the use of a communication book as a service type objective was noted in the PSP. This was a great oversight in programming for every individual at EPSSLC. Moreover, for those individuals referred for placement, the PST failed to take advantage	

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		of their limited time remaining at the facility to intensely focus on the teaching of relevant skills for community living and independence. For example, Individual #132 was referred, but only had these as skill acquisition objectives: • Identify a coin from a worksheet • Put toothpaste onto a toothbrush • Write his name • Measure a half-cup of water • Identify a picture of a fire department • Identify a picture of a fire fighter • Identify a picture of a nurse And, Individual #132 had no training objectives for any type of communication and language skills. The inadequate list of skill acquisition objectives in EPSSLC PSPs begged the question of the adequacy of the facility's skills assessment process in guiding the PST in choosing important objectives for formal (and even for informal) instruction for all individuals at EPSSLC. Please also see further discussion of training objectives in sections F1d, F2a1, and S of this report. Three annual PSP meetings occurred during the week of the onsite monitoring review. All three were observed by members of the monitoring team. Details are provided below for two of these meetings. • Individual #90: His PSP meeting was well-attended. The first topic was a review of all of his rights restrictions. This took an inordinate amount of time and should be done later in the meeting. The QMRP reported that he did this because he expected there to be extensive discussion about the individual's wearing of a helmet (as it turned out there was no discussion or controversy regarding this topic). The QMRP should, however, be able to bring up a specific sole topic more explicitly rather than having to use up 30 minutes (in this example) to review all of the individual's potential rights restrictions when only one (helmet use) was potentially controversial. The meeting then proceeded and the individual's preferences were discussed, followed by a very brief discussion of optimal living and support need areas because so much time was used up during the rights review. The monitoring team, however, noted two parts of the meeting that appeared to meet the intent of the new style PSP, that is, during which there was extensive, relevant, and participatory discussion. o The first was regarding his preference for building models. This led to a	

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		discussion of fine motor skills, milk shakes, drinking of liquids, going to the mall, buying a drink, and other community activities. o The second was regarding his risk of falling. The PT, OT, nurse, psychologist, and direct care staff actively participated. The discussion included wheelchair use, gait trainer use, medication, and types of flooring (e.g., nonslip). The most disappointing part of the meeting was the MRA CLOIP worker's participation. It was minimal and consisted primarily of her recommending that he remain at EPSSLC due to his history of falling, as well as his age, behavior, and lack of community awareness. These comments put an early chill on further discussion of community living and any detailed discussion of obstacles and ways to address any of these obstacles. • Individual #31: Attendance was also good at her PSP meeting and included the facility's new psychiatrist for part of the time. It was the QMRP's first time using the new style PSP format. The individual's preferences and interests were used as the starting point for the meeting and much discussion ensued as the QMRP went through the list. This was by design. As was the case with the other PSP meeting noted above, during this PSP meeting there were at least three occasions where active PST participation occurred. o The first was regarding her ability to walk independently. This led to discussion of holding hands with the individual when walking and this led to a discussion of her preference for certain songs (e.g., the wedding song). The PT, COTA, direct care staff, program developer, and QMRP all participated actively in this discussion. o The second was a discussion of toothbrushing, electric toothbrushes, and the development of a training objective. When discussion turned to having the individual do her toothbrushing while in the shower, the PST PT raised a question to the team regarding the importance of doing what was best for the individual, not what was the easiest. This led to further discussion about electric toothbrushes and the use of two different toothbrushes. o A third had to do with diet sodas, her increase in weight, and different types of soda. After a very extended discussion, the QMRP mercifully said, "Let's bring the conversation back…" and they moved on to other topics. Most interesting was the discussion of community placement. Initial statements indicated that she might do alright in the community with proper support, but she didn't do well with changes in her life and daily routine. PST members, however, noted the progress she'd made and the decrease in her agitation over the past months and years. The PST talked about beginning with some visits to community group homes. The QMRP, however, raised the question about what	

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		was really keeping her from referral other than exposure to options in the community. No one could indicate any real reason or obstacle. The QMRP pushed the team by saying, "As a team do we recommend for community placement?" Everyone did. PST members, then became very enthusiastic about the referral, including the recreational therapist who volunteered to play a large role in taking the individual for visits and helping her to transition. Monitoring of the PSP meeting was being done by the Post Move Monitor (PMM). Five completed forms were submitted to the monitoring team, including one for the PSP meeting for Individual #90 that was observed by the monitoring team. Overall, the monitoring team agreed with the PMM's comments and scoring, that is, that improvement was needed and that the discussions in some areas were rushed. The APC and PMM (and state office) should consider revising this monitoring tool based upon there now being a new PSP format. This monitoring tool was dated 2007. Across the five completed forms, the PMM's comments appeared relevant and useful, but it appeared that the facility was not using this information and data. A better form would make better use of the PMM's time and provide more useful information to the QMRP and to those at the DADS central office who are interested in these data. In addition, the new APC should attend and observe a number of PSP meetings to help develop an appropriate monitoring tool as well as to provide feedback to the facility regarding the way most integrated setting practices are addressed in the new-style PSP format. Based on these observations, review of documents, and discussions with three of the QMRPs coordinator, the following comments are provided regarding the new PSP process at EPSSLC. Positive comments: • The process was very new and will take some time for QMRPs to be comfortable and competent with it. • It was implemented fairly consistently across QMRPs. • Participation from PST members appeared to be greater than in the old style format. • Time was not wasted on topics that were not relevant to the individual or for the bland reading of reports and assessments. • The initial discussion of preferences set the tone that this meeting was about the individual. • Active participation by team members, and competent facilitation by QMRPs can (and did) lead to other important topics (some examples were noted above).	

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		• The list of supports helped to ensure that none were forgotten.
		• Individuals had opportunity to participate.
		
		Comments requiring attention:
		• PSTs may fail to cover all of the important areas due to the more open and free flowing nature of the new format. The QMRPs may benefit from having some sort of checklist (in addition to the list of support/need areas).
		• The LOD/Integrated Discussion was weak in the PSP meetings observed. It will require attention from the QMRP facilitating the meeting if the required components are to be addressed.
		  o The characteristics of an ideal successful most integrated setting (i.e., optimistic vision) were not discussed, but should be.
		  o QMRPs may benefit from having a list of the types of topics to touch upon during the LOD.
		• The written document failed to present the thoroughness and depth of some areas of discussion.
		• Obstacles to community placement should be identified.
		• A relevant set of training objectives should be identified.
		• QMRPs will need support and specific training on how to lead a meeting and to be an effective facilitator. The advantage of the new format also sets the occasion for PST discussions to become in depth, to stray from the important topics at hand, and to include disagreements. Therefore, QMRPs as facilitators (and leaders of these meetings) must be confident and skilled. The monitoring team believes the QMRPs would welcome this type of training. Moreover, the monitoring team was quite impressed with the vibrancy of the QMRPs desire to implement this new style PSP in a competent and valuable manner.
		• A brief paragraph or two regarding the individual's history would be helpful to include in the written PSP.
		
		Obstacles to Movement
		There continued to be no coordinated plan or approach to address obstacles to movement to the most integrated setting across the facility (also see T1g below).
		
		EPSSLC submitted a listing titled "Community Placement Obstacles," dated 11/22/10. It only contained data for four individuals and, further, noted that these were individuals who had a preference for community placement. The obstacles for these four individuals were LAR preference (two), behavior/psychiatric (one), and citizenship/funding issues (one).	

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		Furthermore, strategies to overcome obstacles were not in place at EPSSLC as evidenced in the action plans, specifically in the training objective action plans. 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.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	EPSSLC continued to engage in activities to educate individuals and their families or guardians to make informed choices. The facility had engaged in each of the five activities listed in the DADS policy. This provision item is rated as being in noncompliance due to the need for further activities to occur as indicated in some of the paragraphs below. First, as noted in the previous monitoring report, EPSSLC had developed a new way to conduct their provider fair, that is, they had one provider per day rather than a full day with all providers. They called it the "Summer of Discovery." Sessions ran from 7/9/10 through 8/20/10 and all of the six local providers participated. This was great to see and the creativity of the EPSSLC staff should be recognized. The facility, however, had not done any type of assessment or evaluation of the sessions, such as the number of staff, number of individuals, and number of family members who attended. One way to make the sessions and the overall process of the Summer of Discovery more effective in the future is to do determine specific goals and objectives (i.e., outcomes), a way to measure them, and a way to evaluate the overall effectiveness and success of the fair. In addition, the facility might focus on increasing attendance, providing family members with sufficient guidance before the fair and then escorting them during the sessions to ensure that they have an opportunity to interact with providers who might best meet their family member's needs, and helping providers prepare to answer the types of questions most often raised by family members. Furthermore, the facility should consider other creative ways of educating family members and LARs, such as pairing LARS whose individual has successfully moved with LARS with similar concerns, highlighting success stories, and offering options for individuals to reconnect with families or friends who have moved to the community. A goal of the Summer of Discovery was also to educate staff and PST members about community options. To this end, the facility also conducted a training for approximately 20 QMRPs and facility managers on the new CLDP process. This training occurred in November 2010.	Noncompliance

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		Second, the APC reported that he attended a monthly provider meeting at the local MRA office. Minutes from the 8/26/10 meeting, however, did not indicate any topics directly related to EPSSLC or the individuals served there. Most topics were related to community placement slots and paperwork bureaucratic timelines. 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. The purpose of the CLOIP was to educate individuals and family members about community living options. The CLOIP process had been in place for a number of years. The monitoring team, therefore, recommends that the facility assess the effectiveness of the CLOIP process, that is, whether or not it achieved the outcomes the facility intended it to achieve. For example, the referral of Individual #164 was opposed by his mother. After much effort at outreach by the facility, the APC finally located the mother and met with her. As it turned out, her opposition was due, in large part, to her lack of knowledge about the placement process, her ability to be involved, post move monitoring, and that her son could come back to EPSSLC if his placement failed. Although this was just one case, it made the monitoring wonder about the effectiveness of the CLOIP process in adequately educating family members about referral and placement. Fourth, the facility took individuals on visits to community providers. A six page spreadsheet was submitted to the monitoring team listing most of the individuals and to which of the six providers residential and day programs each individual had visited. This was a great first step, but more work needs to be done, including • Ensure that all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Ensure that PSTs know what information is needed by the coordinator of these tours to make the tour meaningful (e.g., type of home, location, mobility needs). • Obtain comments from staff and individuals, if possible, about the individual's response to the tour. • Incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system (see section E above). Similar comments to these were also in the previous monitoring report for this facility. Fifth, a living options discussion was required to occur and this, as noted above, was occurring at every annual PSP, however, more work (including training and support of the QMRP facilitators) was needed to have these discussions be more comprehensive and	

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		meaningful, especially given the new PSP format. Finally, although not solely related to education about community placements and providers, the recently initiated self-advocacy group at EPSSLC provided an opportunity for another venue to educate individuals about community placement and the community placement process.	
	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. The facility reported that it was not assessing individuals for placement. It was clear that individuals were not assessed for placement as evidenced by two examples: there was no list of individuals whom the PST would refer if not for LAR preference, and there was no list of individuals who themselves had expressed an interest in wanting to explore a possible move to the community. The monitoring team understands the difficulty in determining a process for assessing an individual for placement, that is, what tools, questions, or criteria, if any, should be included. Therefore, as noted in the previous monitoring report, the facility will need guidance from DADS regarding this provision item. Consequently, it is rated as being in noncompliance. If the position of the facility is that the PST goes in with the concept that all individuals can be supported in the community (with very few exceptions), the PSP meeting and PSP document will need to clearly show discussion of the supports the individual needs wherever he or she will be living, obstacles to community placement, and methods to address these with action plans. It is possible that a combination of a document review (of PSP) and an observation review (of PST meetings) could show that the facility did an assessment of the individual for placement. Note that 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 coordination with the Mental	As noted in section T1b above, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Recent training had been conducted by the DADS central office continuity of care coordinator on the new CLDP. The monitoring team had the opportunity to review this new CLDP form. Many of the changes to the CLDP format were in response to discussions that monitoring	Noncompliance

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	Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	team members had with facility and state staff during onsite monitoring reviews, as well as in response to findings noted in baseline monitoring reports. The monitoring team appreciates and acknowledges the facility and state's responsiveness. Some comments regarding the new CLDP form are presented below. Note that this new format CLDP had not been implemented at the time of the onsite monitoring review. Therefore, these comments are based solely upon a review of a blank form. • Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. • The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. It sets the occasion for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual has moved by reviewing the results of each post-move monitoring visit. • A list of standard items to be completed and in place prior to every individual's move now appeared on page 6 (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus upon identifying those essential and nonessential supports that were truly based upon individual needs and preferences. • The list of summaries and recommendations on page 9 was also an improvement. It was designed to help the PST remain focused on its primary task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or nonessential supports. • Psychiatry should be added to the list of summaries and assessments. • The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the monitoring team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or nonessential supports if the PST believes that implementation of any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the state's desire for transition to grow out of the PSP process. • It was also good to see that the CLDP required a description of the evidence to	

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		indicate whether or not an essential or nonessential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. • The pre-move site review should also be sure to include the list of standard items on page 6. This could be added to the list on page 23. The monitoring team looks forward to reviewing the implementation of these new procedures.	
	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 CDLP 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. As noted above, this policy, including the CLDP process, was being revised. The one CLDP reviewed in this section of the report was implemented as per the current policy and procedures. The CLDP activities were coordinated and managed by the APC. He gathered documents, put together a draft CLDP, and organized and ran the meeting. One CLDP and some associated documents (e.g., discharge assessment summaries, PSP) were submitted to the monitoring team and were reviewed. The documents submitted to the monitoring team, however, were still in draft format and had not yet gone through the quality review process that all CLDPs went through. Further, the APC was newly appointed to his position and had not yet been fully trained on the development of an adequate CLDP. Therefore, the submitted documents were considered to be incomplete. Consequently, review of this provision item (and related provision items below) will have to occur at the next monitoring review. It is likely that a number of individuals will be placed between now and then, thereby making completed CLDPs available for monitoring. This provision item addresses the assignment of responsibilities for implementation of the CLDP. This was primarily indicated in the CLDP in sections V. and VI. and was standard in all CLDPs. The CLDP also included a list of essential and nonessential supports, each of which was assigned to a staff member at the provider agency or at the facility. Essential and nonessential supports and their implementation responsibilities are addressed in section T1e below.	Noncompliance

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	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The draft CLDP did not clearly indicate the staff responsible for certain actions and activities.	Noncompliance
	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.	The draft CLDP did not contain evidence of individual and LAR review. The monitoring team's observation of activities related to this sole CLDP, however, showed that the family member (but not LAR) was highly involved in decision making regarding supports and services. The individual himself was not capable of actively participating in discussion regarding supports and services, however, facility staff had taken him on at least 11 different community provider visits. Therefore, the monitoring team has rated this provision item as being in substantial compliance. Appropriate signatures need to be obtained for the final version of 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.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The APC reported that he reviewed all assessments and all assessment updates/summaries in order to ensure that all recommendations were reviewed and considered by the PST during the CLDP meeting. The one draft CLDP submitted was considered to be incomplete and, therefore, the facility was unable to meet the requirement of this provision item. The APC used a one page checklist of assessments that were supposed to be part of the CLDP. It was unclear to the monitoring team, however, as to whether this list was comprehensive and based upon the revised and updated CLDP processes. It is recommended that this checklist be reviewed by DADS central office. Completed accurate checklists could indicate to the monitoring team that all required assessments were indeed submitted, thereby indicating that a comprehensive assessment of needs and supports was completed by the facility.	Noncompliance
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	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	Noncompliance

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	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.	nonessential supports needed to be in place and addressed. Nonessential did not mean not needed. The list of essential and nonessential supports in the draft CLDP was inadequate to meet the requirements of this provision item as also indicated in the previous monitoring report. That is, the comments from the previous monitoring report were not taken into consideration in the development of this CLDP. The monitoring team understands that this was a draft CLDP, the first one done by the new APC, and that it had yet to receive any corrective feedback from DADS central office. Nevertheless, it provided the basis for discussion of supports at the CLDP meeting and even if corrections are made to this individual's CLDP, the opportunity for fruitful discussion of properly developed and worded supports had passed. The listed supports were written in a way that made them difficult, if not impossible to measure or observe. This was noted in the previous review and continued to be a problem. Almost every support was written in this way. The monitoring team understands that the new CLDP process will require the CLDP to describe, in defined observable terms, each support so that it can be observed, measured, and recorded. This will be important in order for EPSSLC to achieve substantial compliance with this provision item. The monitoring team was fortunate to be able to observe the conduct of the CLDP meeting for which the draft CLDP was written (for Individual #164). There was good attendance at his meeting. The APC summarized some of the history of this complicated referral. Then, the individual's mother raised a number of questions that were adequately answered by PST members and staff from the provider agency, including the way medications were to be administered and training for language and communication. Later during the meeting, the individual's QMRP recommended that language and communication be a required support. The monitoring team agreed, but wondered why this was not a part of his programming while he was living at the facility (see T1b1 above). Overall, there was good discussion and participation at this meeting, however, it was unfortunate that essential and nonessential supports were not defined in observable terms, and that methods of evidence of their provision (including criterion) were not determined.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility	As noted in section E (Quality Assurance) of this report, quality assurance processes were at the early stages of development at EPSSLC and, therefore, there was no organized quality assurance process regarding this section T of the Settlement Agreement.	Noncompliance

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	implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	Two activities at EPSSLC, however, were related to data collection on most integrated setting practices and could be incorporated into the facility's QA program. One was the weekly report completed by the APC. The report needed to be improved as described in section T1a above. Once the report is improved, the data from that report could be tracked by the APC and also submitted to the QA department. Certainly, a variety of data can be collected and reported by the APC that would be of interest to the facility's QA department and to its senior management team. Examples include: • Individuals placed • Individuals referred • Obstacles to placement • Action plans related to obstacles • Educational activities The second activity was the implementation of monitoring tools. The APC reported that he and/or the PMM conducted two each month. They were using the monitoring teams' checklist tool. The APC should consider revising the tool to make it more useful for the facility (the importance of revising monitoring team checklist tools for facility use is discussed elsewhere in this report, too). Further, the APC and PMM should implement this monitoring across a sample of all individuals, not only those who have been referred. This is important to do because they have so few referrals from which to choose, and because many of the provision items apply to all individuals at the facility, not only to those who have been referred. The monitoring team also recommends that the APC contact the Lufkin SSLC APC to learn about the types of quality assurance activities that have been initiated there.	
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	EPSSLC was not in compliance with this provision item. EPSSLC was not gathering, and was not 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 developed an initial report designed to ultimately meet the requirements of this provision item.	Noncompliance

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	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.	The statewide report provided an overview of how obstacles were to be identified, a definition of each of 12 different categories of obstacles, and a description of 11 steps the state and facility might take to address some of these obstacles. As discussed with DADS management, the goal was for the state to gather all of the data on the 12 categories of obstacles and create a statewide plan. In addition, the statewide report would include • an appendix for each of the SSLC that provided data specific to that facility, • additional information specific to that facility, such as related to location, population, staffing , and • steps to overcome that facility's specific obstacles. Some obstacles might be able to be resolved at the facility-level, while others will need state intervention. The data that will be used were being entered into the system as each individual planning session transpired. This was to occur beginning 9/1/10. This appeared to be a reasonable approach to reaching substantial compliance with the requirements of this provision item. The monitoring team recommends that further information be collected regarding one type of obstacle, that is, LAR preference for the individual to remain at the SSLC. Rather than solely listing this as an obstacle, the report should indicate the reasons for the LAR's preference (i.e., reluctance to support referral). This information will be helpful to DADS and to each facility.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community	The monitoring team was given a document titled "Community Placement Report." It was dated 1/6/11, included information for all of calendar year 2010, and had six sections • current referrals (eight individuals) • community placements (four individuals) • rescinded referrals (four individuals) • three sections regarding individuals who were not referred for various reasons(no individuals) This provision item was found to be in substantial compliance given the current contents as well as the facility and state's intention to include, in future Community Placement Reports, a list of those individuals who would be referred by the PST except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T1a, professionals on individuals' teams need to	Substantial Compliance

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	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.	make independent recommendations regarding the appropriateness of an individual for community placement. The state indicated that at this time, its data system did not include this information, but it was working toward being able to produce these data in the near future.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living 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	EPSSLC was implementing the post-move monitoring process. The facility was fortunate to have a competent post-move monitor. Since the last onsite review, post-move monitoring was conducted for Individual #150 (45- and 90-day monitoring) and for Individual #124 (7-, 45-, and 90-day monitoring). Individual #124's 90-day post-move monitoring was completed during the week of the onsite review. The monitoring team appreciated the efforts of the PMM to complete the post-move monitoring document immediately after the visit so that it could be included in this review. These five post-move monitoring visits were 100% of the post-move monitoring that was required, that is, due to the few placements that occurred, very little post-move monitoring was required. The post-move monitoring was completed within the required timelines. All of the completed checklists followed the requirements of Appendix C of the Settlement Agreement. Post-move monitoring continued to include a visit and observation at the residence when the individual was at home and a visit to the individual's day program site. As a result, it sometimes required a number of days for the PMM to complete the post-move	Noncompliance

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	best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	monitoring. This demonstrated a thoroughness in post-move monitoring and the monitoring team was impressed by it. A new post-move monitoring form was developed by DADS and was implemented by the PMM for the first time for Individual #124's 90-day monitoring. The monitoring team reviewed this new form. For the most part, it was the same as the previous form, but included improvements, such as a place to indicate where the visit occurred (e.g., home, day program), and a column for evidence for each support. Once implemented properly, this column should indicate the evidence as determined by the PST during the construction of the CLDP. The PMM will, therefore, need to enter the evidence she found in the comments section. After reviewing the implementation of the new form and the resulting completed document, the monitoring team found, unfortunately, that the design of the form had the unplanned effect of stopping the conduct of some of the very things that the monitoring team very much liked about the way post move monitoring was conducted and documented at EPSSLC. In fact, over the past few months, the monitoring team referred many APCs and PMMs at other facilities to the EPSSLC post move monitoring checklists as exemplary models. Three issues with the new PMM form are presented below: • Previously, the EPSSLC PMM made detailed and lengthy notes about the status of each support following all three post-move monitoring visits. Her notes were very informative and provided very useful information to the reader of the document. Moreover, the PMM added her notes, in a cumulative manner, across all three reviews. This resulted in the 90-day form including all of her notes and comments from all three reviews. Consequently, all post-move monitoring information was in one place, making it easy for the reader to learn about progress, stability, successes, problems, and so forth. The new format instead had only a narrow column on the right side for comments. The monitoring team recommends that the form be revised to include a larger space for comments. One way to do so would be to create a row under each support instead of using a narrow column. Making it standard practice to add notes in a cumulative manner is also recommended. The EPSSLC's post-move monitoring forms were lengthy because the information was relevant, well-written, and easy to read; the resultant length should not be considered a detriment. • The previous form had a column for the PMM to indicate yes/no/na for each support. The new form did not contain this column, but should. This will make it easier for the reader to quickly determine the PMM's evaluation of the presence or absence of each support. PMM comments, without the forced	

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		indication of yes/no/na, will not be sufficient to indicate the thorough post-move monitoring of each support. • The inclusion of a column to indicate the evidence that the PST determined would be required to be present to indicate presence of the support was an excellent and needed addition to the post move monitoring process. The determination of evidence is something that should be discussed and determined by the PST (with input from the APC and PMM) during the planning for transition, including, most importantly, in the finalization of the CLDP. The description of evidence, however, needs to include criterion, too. For example, Individual #124 had a support, "enjoys taking walks" with desired evidence listed as "progress notes." This gave the PMM little to work with. For example, there was no indication as to the number of walks that should occur each week or month, the length of time of a walk, or where the walks should occur. Similarly, he had a support "assure that he has his unifiber and drinks plenty of liquids to assist him with his bowel movements." There was no indication of what the PMM should look for or at what criterion should occur. Consider that the criterion could be amount of unifiber consumer, amount of liquid consumed, and/or number of bowel movements. Making this type of determination should not be the PMM's responsibility; instead it should be done by the PST, most preferably, during the CLDP meeting. Thus, the PST, at the CLDP meeting, needs to identify, for every essential and nonessential support: o what evidence should be present o the criterion for this evidence Even so, some discretion will need to be left to the PMM if the criterion, or support changes. For example, one of the supports for Individual #124 was to allow him to wear his cap. After moving, he no longer preferred to wear his cap. Further, he no longer needed to have a supervision card available or carry around his water bottle. All of these were indications of the progress he had made and his level of comfort at his new home. In these cases (of which there are likely to be many), the PMM should be required to come back to the individual's PST at the facility for PST comment and to get approval to allow for certain supports, such as these examples, to no longer be required. This could then be indicated on the PMM form. This item is being rated as being in noncompliance, even though it was rated as being in substantial compliance in the previous monitoring report. This is not a reflection of the hard work of the PMM; it is due to the need for changes to occur in the post-move monitoring process so that the PMM can assess whether supports called for in the individual's community living discharge plan are in place. The monitoring team and the PMM had the opportunity for numerous productive and interesting discussions regarding post-move monitoring during the week of the onsite review. The monitoring	

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		team expects that with the above changes, this provision item will be found to be in substantial compliance again at the next onsite review. The APC and PMM reported that they had a very good working relationship with the providers and had not needed to resort to notifying the MRA, DADS, or any regulatory agency in order to gain their compliance in providing any of the required supports.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	As noted above in section T2a, post-move monitoring visits were occurring at EPSSLC. The monitoring team had the opportunity to accompany the post-move monitor on a visit to the group home and day program of Individual #124 for the conduct of the 90-day post move monitoring visit. The monitoring team wishes to thank the PMM and the community agency for making arrangements for this visit to occur. The purpose of this visit was to learn about the post-move monitoring process, see the community home and day program, meet the individual, learn about transition and services, and see the status of some of the essential and nonessential supports. Individual #124 attended a day activity program five days per week. Sixteen other individuals were present at the day program during this onsite review. The space was pleasant and bright, activities were occurring, and the Individual #124 appeared to be very happy. His home was in a very nice residential neighborhood. The home was clean, nicely furnished, and spacious. He lived with three other individuals. They were having dinner at the time of the onsite review. All individuals were seated around the table and their meals looked very appetizing. The individual was using his adaptive mealtime equipment, as required. The house manager and two direct care staff were present. The staff appeared to be very knowledgeable about the individual. They noted that he was usually happy was sleeping better than he had when he first moved in. In addition, he no longer carried around his water bottle and no longer wore a cap (or multiple caps) as he had when living at EPSSLC. He kept these items in his room and had access to them when he wanted. The PMM actively engaged in the conduct of post-move monitoring in a respectful, professional manner. For example, she did not hesitate to ask questions, require documentation, and schedule an additional visit to complete the post-move monitoring. Of particular note were extra efforts taken by the PMM subsequent to Individual #124's move. The PMM found that the group home staff were not as skilled as she thought they might be regarding dysphagia, food textures, and food preparation. As a result, she	Noncompliance

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		coordinated a training conducted by EPSSLC SLPs and dietary staff that occurred at the EPSSLC campus and was attended by most, if not all, of the individual's staff and managers at his new program. A rating of noncompliance, however, was given to this provision item because of the difficulty in determining the accuracy of the facility's monitoring when essential supports were not worded in a manner that was unambiguous, well-defined, and criterion-referenced. If the PMM is provided with more direction in this regard from the PST and the APC via the CLDP process, the monitoring team is confident that the facility will achieve substantial compliance with this provision item, most likely during the next onsite review.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	
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	EPSSLC had not had any alternate discharges during the past six months.	Not rated

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	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.		

Recommendations:

1. Implement new DADS policy on most integrated setting practices, when it is disseminated.
2. Consider whether EPSSLC facility-specific policies would be helpful. DADS central office may be able to provide guidance and consultation on this.
3. Provide competency-based training for QMRPs regarding how to facilitate and lead these new style PSP meetings.
4. Ensure that a thorough and meaningful discussion of optimistic optimal living characteristics occurs during the PSP meeting. Ensure that the optimistic living vision section of the PSP addresses the individual's needs for success in the community, not only his or her preferences.
5. Identify and address the identified obstacles to each individuals' movement to the most integrated setting within the PSP for each individual.
6. Ensure that the opinions of professionals regarding referral are obtained and documented, separate from the preferences of the LAR and the team as a whole.
7. Ensure the written PSP document reflects the level of intensity of discussion that occurred at the meeting.

8. Ensure that relevant information is submitted and monitored by the QA department. Ensure that quality assurance processes are applied for all of section T, including but not limited to T1g.

9. Provide regular information on section T activities to senior management. Senior management should review and be knowledgeable about referral and placement practices at EPSSLC, as well as the status of those individuals who have moved, been referred, or not been referred, or whose referrals have been rescinded. The monitoring team suggests contacting the Lufkin APC to learn about her weekly written report and weekly presentation to senior management.

10. Create a list of individuals who have requested to move, but have not been referred.

11. Create a list of individuals who would be referred except for the preference of the individual's LAR. This list should be for individuals who can, as well as those who can not, express a preference. This list may contain some of the same names as in the list noted in the recommendation immediately above this one. In addition to obtaining names from QMRPs, names to include on this list may be obtained from a review of CLOIP worksheets and the PSP LOD. This information should be reported as part of the admission and placement department's data/QA activity.

12. Individualize a plan to support families who are not supportive of the PST's referral of their family member.

13. Ensure that training objectives are related to community living and to any identified obstacles. For those individuals who are referred, a larger set of training objectives should be considered.

14. Include training objectives specifically on language and communication in PSPs (also see section R of this report).

15. Revise the PSP LOD monitoring form. Use the results in a meaningful way.

16. Identify and address obstacles across the facility by conducting a comprehensive assessment and analyzing the information as required by provision item T1g.

17. Determine desired outcomes and assess the effectiveness of educational activities, including the provider presentations, MRA trainings, the CLOIP process, community tours, and the self-advocacy meeting.

18. In the self-advocacy meetings, teach decision-making, and problem solving skills.

19. To address the provision for assessing each individual for placement, include a specific statement in the PSP as to how this was accomplished.

20. Implement and assess the updated and revised CLDP procedures.

21. Consider the comments given in section T1c regarding the new CLDP form, including (a) add psychiatry to the list of assessments, (b) reword or remove the comment on page 12 regarding action plans, and (c) include the standard items from page 6 in the pre-move list on page 23.

22. Use an approved checklist to indicate that all required assessments were completed and submitted within the required timelines of this provision.

23. Improve the way important essential and nonessential supports are included in the CLDP:
    a. Begin developing the list of supports prior to the CLDP meeting.
    b. Ensure that all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
    c. Define each support in observable and measureable terms.
    d. Define the manner in which the presence of each support will be verified.
    e. Include a criterion along with the evidence required for each support.

24. In the Community Placement Report, include a listing of individuals whose PSTs have determined can be appropriately placed but were not referred due solely to LAR preference.

25. Implement and assess revised post-move monitoring procedures.

26. Consider revising the post move monitoring form as per the comments in T2a, regarding (a) making more room for comments, (b) providing comments in a cumulative manner across the three visits, (c) including a yes/no/na column, and (d) specifying evidence and criterion for each support.

The following are offered as additional suggestions to the facility:

27. The APC should read the section T from previous monitoring reports for EPSSLC as well as from the reports from the other facilities monitored by this monitoring team.

28. The APC should attend and observe a sample of PSP meetings.

29. Add a section to the PSP form to allow for a brief description of relevant aspects of the individual's history.

30. Modify the monitoring teams' checklist tools to be more useful to the APC and PMM.

31. DADS should provide feedback and suggestions on EPSSLC's CLDPs to the APC. In addition, consider creating a metric to measure the quality of the CLDPs and consider creating a criterion to indicate that the facility has mastered CLDPs. This might then result in less frequent reviews of CLDPs eventually being necessary.

32. Schedule more PSPs to occur during monitoring team's onsite review weeks. Similarly, schedule PSPs to allow the monitoring team to observe PSP meetings led by many different QMRPs.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o Human Rights Committee (HRC) meeting minutes 8/1/10 – 10/30/10 o Priority for guardianship list for 53 individuals o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans for: • Individual #109, Individual #103, Individual #132, Individual #79, Individual #100, Individual #89, Individual #31, Individual #90, Individual #110, Individual #111, Individual #39, Individual #104, Individual #18, Individual #93, Individual #195, Individual #4, Individual #88, Individual #58, and Individual #73 Interviews and Meetings Held: o Gloria Loya, Rights Officer Observations Conducted: o Observations at all residences and day programs o Annual PSP meeting for: • Individual #60, Individual #31, and Individual #90
	Facility Self-Assessment: The facility's POI indicated that the facility had started to develop a prioritized list of individuals in need of an LAR and was waiting on further direction from the state office in terms of training to address this provision. They had assigned a rating of noncompliance to all items in this provision. The monitoring team agreed with the finding of noncompliance for this provision.
	Summary of Monitor's Assessment: Since EPSSLC did not indicate it was in compliance with any of the provisions of this section, and particularly since it indicated it was waiting on the final statewide policy and training before taking most actions, the monitoring team reviewed a small sample of documents in order to be able to assess progress, if any, from the previous review and provide any additional recommendations that may be helpful to the facility when it does undertake action in these provisions. Comments are as follows: • Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, not all individuals had been assessed and not all PSTs were adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. The facility reported little activity or

	planning to solicit guardians for those determined to be in need. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had an active Human Rights Committee in place to review restrictions requested by the PST. Some PSTs were holding good discussions around the need for guardians while other teams were only minimally discussing the capacity for individuals to make decisions and give consent.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	EPSSLC did not have a policy in place for developing and maintaining a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The state developed a draft policy to address this provision, but had not yet released it to the SSLCs for implementation. The facility's POI indicated that it plans to take action in these areas once the policy is finalized. According to the Rights Officer, the facility did have a procedure in place for determining need for guardianship. They used a standardized tool titled, Determination for Need of Guardian/Priority Tool. The tool was designed to be completed by the QMRP with input from the PST and assigned a priority rating of Priority I, Priority II, Priority III, or non-priority based on the list of five factors: • Has been deemed incompetent through the court system and currently does not have a guardian • Has a high risk and/or history of abuse, neglect and/or exploitation • Has serious ongoing medical/psychiatric issues • Has severely impaired communication/developmental disability and/or diagnosis of severe/profound mental retardation • Other as determined by the PST This was rated with consideration of whether or not the individual had a guardian, involved family member, correspondent, or advocate. The facility provided the monitoring team with a prioritized list of 53 individuals at the facility and their guardianship status. The individuals were rated as follows, with Priority I designated as individuals with the greatest need for guardianship: • 25 (47%) had guardians • 43 (81%) had advocates • 19 (36%) were priority I • 2 (4%) were priority II • 32 (60%) were priority III	Noncompliance

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		40% of the individuals at the facility were included on this list. In 19 PSPs reviewed, there were 10 individuals (53%) who did not have guardians. There was at least minimal discussion of the individualized need for an LAR in eight (80%) of the 10 PSPs for individuals who did not have guardians. Examples included: • Individual #4 had no guardian. His sister was listed as his advocate for him and the PSP indicated that the team discussed guardianship with her. She did not agree to pursue guardianship. His Rights Assessment indicated that the team had determined that he was unable to give informed consent in the areas of medical, programmatic, financial, restrictive or intrusive practices, media/photo, and release of records. He had been referred for guardianship and was determined to be a Priority I (high need). • Individual #103 did not have a guardian. The PSP noted that her parents advocated for her and had recently re-applied for guardianship. She was not on the list of individuals in need of guardianship. • Individual #18's PSP indicated that he had no guardian, but did have an advocate. The PSP indicated that the team discussed guardianship and referred him to the Guardianship Coordinator on 11/1/10. The Priority for Guardianship list indicated that he was a Priority I with no guardian or advocate. The PSP indicated that his sister advocates for him and is involved in his life. The QMRP stated that she will send guardianship information to his sister. • Individual #93's PSP indicated that she had no guardian, but her sister advocated for her. The PST determined that she was unable to give informed consent in the areas of medical, programmatic, financial, restrictive or intrusive practices, media/photo consent, and release of records. The PST stated that she was not referred to the guardianship coordinator because her mother and sister advocated on her behalf. Guardianship information was sent to the mother. The Priority for Guardianship list indicated that she was a Priority I (high need) for guardianship. • Individual #110 did not have a guardian or advocate. The PST referred her to the Guardianship Coordinator on 11/2/2010. The PST noted that she had no correspondent or LAR and was recommended for guardianship, since she had been recommended for community placement and could not make decisions on her own. The Priority for Guardianship list indicated that she was a Priority I (high need) for guardianship. • Individual #31's PSP indicated that she had no LAR. In her living option section of the PSP, it was noted that "she did not respond when discussing her living	

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		options. She seems to have trouble displaying preferences, and it is unknown how much she understands about living in the community or what her options might be." The team did not discuss her need for guardianship. • Individual #104 had no guardian, but did have an advocate according to his PSP. The PSP stated that he was not referred to the Guardianship Coordinator because his mother wanted to become his guardian. Information was provided to his mother regarding guardianship. His PSP was dated 6/10/10. He still did not have a guardian in place and there was no indication that the team had met again to review his status on guardianship. • Individual #100's PSP was not clear on whether or not he had a guardian. It indicated that his sister was his correspondent. In the discussion of rights restrictions, there was a statement that he could not vote because he had a guardian. There was no other indication in his plan that he had a guardian and guardianship issues were not discussed by the team. The two PSPs that contained no discussion around the need for guardianship were two of the newer PSPs. It will be important as the facility revises this process to ensure that teams remember to discuss the need for guardianship and make referrals as appropriate. The guardianship coordinator at the facility reported that she had been working with a local nonprofit guardianship agency to pursue guardians for Priority I individuals. The agency had provided guardians for three individuals at the facility. She had also been working with Advocacy, Inc. to pursue advocates for individuals without guardians or advocates. All QMRPs had attended the Texas Guardianship Conference in November 2010 to learn more about guardianship. The facility was not in compliance with this provision.	
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	EPSSLC did not have policy or procedure established to implement this provision item. It reported it was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific documents. According to documentation provided to the monitoring team, there was one individual at the facility who had obtained a guardian since 6/1/10. The facility did have some rights protections in place including an assistant ombudsman housed at the facility and a rights officer employed by the facility. Both were well known	Noncompliance

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	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.	and actively involved with the individuals at the facility. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at EPSSLC. The HRC, chaired by the human rights officer included representatives from the community, and facility staff from a number of disciplines. There was also a self-advocacy group on campus. The monitoring team attended the self-advocacy meeting held the week of the monitoring visit. The group was led by the rights officer and encouraged individuals to begin advocating for themselves. See sections E and T of this report for more discussion around self advocacy. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals. The facility was not in compliance with this provision.	

Recommendations:

1. Develop a list of LAR providers in the area.

2. Continue to 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.

4. Continue to explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals.

5. Ensure that any restriction of rights for an individual is approved through the Human Rights Committee approval process.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o EPSSLC Organizational chart, not dated o EPSSLC policy list, two pages, not dated o List of typical meetings that occurred at EPSSLC o EPSSLC POI, December 2010 o EPSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 1/3/11 o Table of contents for the active record and the individual notebook o List of all staff responsible for management of unified records o Materials used in new employee orientation regarding unified records o Blank staff survey form regarding unified records o Description of how documents flow from completion to filing in the record o Description of how the facility implements and assesses implementation of provision item V4 regarding the use of records to make decisions regarding service provision o Completed monitoring team checklist tools for September 2010 and October 2010 showing audits of five records each of those two months o Active records of many individuals who lived at EPSSLC during observations in residences o Review of active records and/or individual notebooks of: • Individual #157, Individual #126, Individual #42, Individual #74, Individual #32, Individual #107, Individual #129, Individual #164, Individual #53, Individual #31, Individual #90, Individual #172 o Review of master records of: • Individual #65, Individual #161 Interviews and Meetings Held: o Priscilla Munoz, Medical Records Coordinator o Priscilla Guevara, Unified Records Coordinator o Helen Alvarez, Settlement Agreement Coordinator o Residential Unit Director: Jeff Moody o Neda Daniels, nurse recruiter o Numerous staff and clinicians during observations in residences Observations Conducted: o Records storage areas in residences o Overflow and master records storage area

	Facility Self-Assessment: The facility's self-assessment, called the POI, for this provision indicated that all four provision items were self-rated as being in noncompliance. The POI was revised since the last onsite review. The new version was shorter and more likely to be useful to the facility. It listed the four provision items, what the facility did or planned to do for each provision item, and four additional outcomes and actions. The POI was completed only a few weeks prior to this onsite review and the monitoring team highly recommends that the facility revise the contents of the POI based upon the comments, recommendations, and suggestions given below in this section of the report. The new style POI was designed to integrate with the monitoring report and the facility will be more likely to achieve substantial compliance if it revises the POI after receiving this report. The monitoring team was in agreement with the facility's self-rating of noncompliance.
	Summary of Monitor's Assessment: EPSSLC made progress towards meeting this provision of the Settlement Agreement. The new policy and recordkeeping practices were implemented across the facility. The unified record for every individual was created, including a reformatted active record and a brand new individual notebook. A master record, however, was not adequately in place and needed to be. The unified records consisted of a multi-volume active record, an individual notebook, the beginnings of a master record of historical and legal documents, and an overflow record of thinned and purged materials. The new records followed the state's policy. The active records and individual notebooks were organized according to the required format. Overall, the new records were neat, entries were made as required, and most required documents were contained in the record. A small number of errors were found in a review of the active records, indicating the need for ongoing reviews and audits, as were just being initiated at the facility. The medical records coordinator and the unified records coordinator were committed to having an organized, user-friendly recordkeeping system. They were knowledgeable about the records and were interested in improving the records as implementation of this new system moved forward. Comments from staff at all levels indicated an overall satisfaction with the new recordkeeping practices, however, comments during brief interviews with the monitoring team indicated that the individual notebooks may be too cumbersome, and data collection might not be done reliably, especially for recording the occurrence of problem behaviors. The facility should explore these possibilities. Audits as per provision item V3 had begun in September 2010. This was good to see. The audit system, however, required improvement to ensure that all contents were reviewed as per the table of contents, and

	that all components of the unified record were reviewed, including the individual notebook and master record. In addition, a system was needed to ensure that corrections were made to the records based on the audits. The facility had made an initial attempt to address provision V4, the usage of records in making care and treatment decisions by requiring the facility's many disciplines to make entries in the integrated progress notes. As noted below, this may be one component of the way this provision is assessed, but it is likely to be insufficient to meet this provision item's requirements. EPSSLC had conducted a staff survey as recommended in the previous monitoring report. Data now needed to be summarized, assessed, and acted upon. Overall, the survey indicated satisfaction with the new recordkeeping practices at the facility (although, as noted above, during interviews some potential problems were identified).

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	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. DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1, was dated 3/5/10, and was adopted in full by EPSSLC. There were no facility-specific policies regarding recordkeeping. EPSSLC should consider whether a facility-specific policy would be helpful in achieving substantial compliance with this provision. EPSSLC made considerable progress in meeting this provision since the previous onsite review. At the time of this onsite monitoring review, all of the records at the facility had been converted, and every individual was reported to have an active record that was in the new format, as well as an individual notebook. The completed unified record consisted of the following, as required: • Active record • Individual notebook • Master record (though see below) • Overflow files The conversion of the old records to the new active records, and the creation of the individual notebooks was a very large task and required a great deal of effort from the recordkeeping department staff as well as from other departments and operations at the facility. The monitoring team wishes to acknowledge this as well as the ongoing efforts at the facility to meet this provision of the Settlement Agreement. The record	Noncompliance

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		conversions were completed a few months prior to the onsite review and although more work was needed (and was going to be done) to ensure they were useable, of a manageable size, and that all aspects of Appendix D were being followed, staff were becoming more and more comfortable with the new recordkeeping systems. EPSSLC was fortunate to have maintained the same staff who had primary responsibility for addressing the requirements of this provision since the last onsite review. The facility's records activities were overseen by Priscilla Munoz, the medical records coordinator, with the assistance of Priscilla Guevara and an administrative clerk. Priscilla Guevara was the unified records coordinator. The medical records coordinator and the unified records coordinator were the leads for this provision. They were professional, organized, and committed to doing whatever was necessary to meet the requirements of this provision. They were eager to receive feedback and suggestions and to make changes to recordkeeping practices if needed. Since the previous review, the recordkeeping department had: • created and implemented a training for new employee orientation regarding recordkeeping practices at EPSSLC • created and implemented a staff survey to learn about staff experience with the new unified records and to solicit suggestions for improvement. The survey was written so that it would be easy for staff to respond. A number of responses had been received, and most were positive. The conduct of this survey was in direct response to a recommendation made in the previous monitoring report. The monitoring team appreciated the facility's responsiveness to the recommendation. The monitoring team suggests that the facility now use the information that had been received, rather than waiting on additional responses. Their responsibilities also included thinning of the records (except that the QMRPs had responsibility for thinning of each individual's volume 1 of the active record), and storage of the records. It appeared that these three staff should be able to manage the records according to the new policy. The recordkeeping staff and the nurse recruiter told the monitoring team about a recent problem that arose regarding the placement of the seizure records, that is, whether it would best be in the individual notebook or the active record. This required discussion among the recordkeeping staff, nurses, and residential services. A reasonable solution was reached, to have the seizure form in the individual notebook so that staff could immediately record the relevant seizure information, but that the completed form needed to be immediately (i.e., later that day) be moved into the active record so that the information would be available to other clinicians who needed to have that information.	

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		Active records 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 constructed following the order of sections from the state's table of contents. The active records were divided across the binders in the same way for all individuals across the facility. In the opinion of the recordkeeping staff, direct care staff, clinicians and nurses, and facility managers (e.g., unit director, house supervisors), 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 active records contained the state-provided table of contents. A review of observation notes and IPNs in the active records indicated that they appeared to be in good format, easy to read, and ordered correctly (note, this comment refers to the format and appearance of the observation notes and IPNs, not to their content; content is reviewed when applicable in the review of each provision of the Settlement Agreement in the other sections of this report). The active records of Individual #126, Individual #74, Individual #129, and Individual #53 were reviewed in some detail. • Overall, the records were neat and clearly labeled. • SPOs were paper clipped to separate the SPOs from one another. It would be better to separate with sheet dividers, such as green pieces of paper as done in other facilities. • There was some duplication of documentation, such as there being PSPAs in two different sections: PST discussion, and PSP reviews (Individual #126). • Observation notes had large gaps between entries, such as only eight entries in a three month period (Individual #129) • PSP was out of date, from 9/1/09, and an old "IPP" review from 3/07 was in the active record (Individual #53). Direct care staff noted that the new records were easy to use (e.g., for Individual #157), and one of the RNs said that the new active records were easier to use, but difficult for the more veteran staff for whom it was taking some time to get used to the new format. Individual notebooks	

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		Individual notebooks were in place as per the state's policy. The individual notebooks reviewed by the monitoring team appeared to contain most everything required by the facility's table of contents. Heavy large hard cover binders were being used at EPSSLC for the individual notebooks. This made the individual notebooks more cumbersome for daily use. As a result, individual notebooks were often observed in the backpacks of individuals rather than out and available for staff use (e.g., observed in House 509). EPSSLC should assess the contents of the individual notebooks and ensure that they do not contain anything that is not required or useful. For example, pages of laminated communication icons were in each individual's individual notebook. The monitoring team did not observe one occasion where these were used by staff or by individuals. Perhaps their inclusion in the individual notebook both hindered their use and made the individual notebook more weighty and less easy to use. Another example was the inclusion of a section for the individual's daily schedule. These were not detailed and were not used, useful, or functional. Perhaps the daily schedule section could be removed. Direct care staff from across the campus were briefly interviewed by the monitoring team regarding the individual notebooks. Their comments are summarized below: • An MRA II noted that sometimes the individual notebooks opened and papers fell out. Even so, she liked having the individual notebooks, especially having the PNMP readily available. • An MRA II with two years experience at EPSSLC liked the individual notebooks. In particular, he noted that everything was together for the individual, but that the communication pages made it too full. • An MRA I said that the individual notebooks were good and were better than what they used to have. • A recreation therapist stated that the individual notebooks were good to have. • An MRA I with six months of experience at EPSSLC said that papers often fell out of the smaller ringed binders, and that there were too many books such that she could not easily record data (i.e., on target data sheets that were in each individual notebook). Instead, she recorded data on a small notepad and copied it over later. This was the monitoring team's only indication of this practice. Nevertheless, the facility should look into whether this is typical practice in the homes and day program. <u>Master records</u> Master records had never been kept at EPSSLC and were only recently initiated due to	

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		the requirements of the new recordkeeping policy and the Settlement Agreement. The master record for each individual was a small set of documents placed in the front of the overflow file for that individual. EPSSLC did not, therefore, have a discrete file for each individual that was his or her master record. The recordkeeping staff should contact the DADS central office as well as the San Antonio SSLC and San Angelo SSLC to see examples of ways of setting up the master records. A table of contents was used at these two SSLCs to help recordkeeping staff in maintaining the records, as well as to assist the URC in completing audits of this component of the unified record. Two master records were reviewed in detail. One was for an individual who had lived at EPSSLC for many years (Individual #65) and the other record was for an individual who had been placed at EPSSLC more recently (Individual #161). Both master records contained minimal information, such as guardianship papers and a diagnostic evaluation. <u>Overflow files</u> Documents taken from each individual's records were stored and managed by the recordkeeping staff according to the record thinning schedule provided by the state. The overflow documents were kept in the medical records office. EPSSLC was close to achieving substantial compliance with this provision item. Further refinement of the active records, attention to the problems in usage of the individual notebooks, and creation of master records will be required, as indicated above.	
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). Facility-specific policies are likely to be developed as DADS completes its set of statewide policies. Then, as noted throughout this report, the facility will need to ensure that any facility-specific policies are in line with the state policy and that approval is obtained from the DADS central office.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with	Quality assurance procedures to meet the requirements of this provision item were not yet in place, but the facility had very recently begun some activities in this area. That is,	Noncompliance

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	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.	the medical records coordinator and the unified records coordinator had begun to do reviews of a sample of unified records each month. Specifically, they had conducted five reviews for September 2010 and five reviews for October 2010. They used the monitoring team's checklist tool for provision V. It was good to see that the facility had begun to conduct formal reviews of records. In order to meet the requirements of this provision item, the recordkeeping staff need to look at the contents of the unified records, too. A first step would be to modify the monitoring tool to be more useful to the recordkeeping staff. For example, the contents of the records according to the required table of contents should be part of the quality review. The monitoring team recommends that the facility contact the URC at the San Antonio SSLC to learn about her audit process and tools (the monitoring team discussed this with the recordkeeping staff during the onsite review). Further, the review of the unified records should include all of the components of the unified record, not just the active record. Therefore, the review needs to include the individual notebook and the master record. The review system needs to include a method for summarizing the data from the reviews into a manageable understandable list that can be presented to the home manager and QA department. The system also needs to include a method for tracking needed corrections to completion. The monitoring team did not see evidence of any detailed feedback being provided based upon the first two months of reviews that were conducted. The monitoring team had the opportunity to discuss the auditing process at length with the medical records coordinator and the unified records coordinator. The monitoring team appreciated their interest in improving their service and meeting the requirements of this provision item.	
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. The monitoring team discussed this provision item at length with the medical records coordinator and unified records coordinator. They said that following this discussion they had a better understanding of this provision item. The facility will have to come up with a way to determine if facility staff are routinely utilizing the records in making care, medical treatment, and training decisions. The facility should work with DADS central office, as well as with the other SSLCs to determine how to do so. The facility's description of how it addressed this provision	Noncompliance

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		item only spoke to the requirement for the facility's many disciplines to write notes in the integrated progress notes. Although this is one indication of the use of records, alone, it is not a sufficient way for the facility to show that it routinely uses the unified record to make care, medical treatment, and training decisions. Most likely, a set of activities will have to occur, including, for example, interviews of clinical staff to learn how they use the records (e.g., psychology, nursing, habilitation), a review of the contents of IPNs, and an examination of medical consultations. The facility might consider piloting some of these activities before the next onsite review. Some comments, based upon observations of the monitoring team, regarding the use of the records as required by this provision item are provided below. These illustrate some examples of the use of the unified record, but also show some of the challenges for the facility to address in meeting the requirements of this provision item. • At Individual #31's PSP meeting, the active record volumes were available and were used by the psychiatrist and the psychologist. The psychologist used the records when there was discussion about the individual's frequency and type of behavior problems. This was good to see and immediately answered the PSTs question about the most recent occurrence of certain behaviors. • At Individual #90's PSP meeting, the three binders of his active record were on the table, but were not used at all. • At Individual #172's PFA meeting, the psychiatrist looked for her record and questioned why it wasn't present. The house supervisor went and got volume 2 of her active record. • The medical staff appeared to utilize the active records to obtain information needed to make treatment decisions. • A recent change in dictation systems provided a one hour turn around time such that the information could be quickly placed in the records for review by all team members and treating professionals. • Although the format of the nurses notes changed, as indicated by the CNE, from DAP to SOAP format, there was almost no relationship between the structure of the notes and their content. For instance, the documentation that followed the letter "S" was almost never "subjective" data; the documentation that followed the letter "O" was sometimes "objective" data; the documentation that followed the letter "A" was almost never a complete "assessment;" and the documentation that followed the letter "P" was almost never a "plan." More attention will need to be paid to these entries so that the new SOAP format supports the desired function: complete documentation of findings, assessments, and plans. • Often, documentation of nursing assessments and nurses' response to reports of changes in individuals' health status stated that "monitoring" and "follow-up"	

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		would occur, however this was not evident in the 20 sample individuals' records reviewed in section M of this report. • Since the previous monitoring review, the legibility of nurses' notes, signatures, and credential had declined. • Psychiatry was now documenting in the integrated progress notes in addition to typewritten documentation of the clinical encounter. This was an improvement from the previous onsite review. It integrated psychiatry information into the flow of the medical component of the active record. • The graphs reviewed did not include noteworthy events (e.g., medication changes, situational stressors) and, therefore, these graphs were not as useful as they might have otherwise been to medical and psychiatry staff. • Staff appeared to be regularly using the individual notebooks to record target behaviors, replacement behaviors, review PBSPs, and record SPO data (though see comment above in V1 regarding at least one exception). • Habilitation therapy clinicians did not utilize the Integrated Progress Notes.	

Recommendations:

1. Consider the development of facility-specific policies.
2. Address aspects of the active records of the specific individuals noted in V1 above.
3. Add a list of SPOs to the front of the SPO section of the active record to indicate all SPOs that should be included in that section of the record. The list should come from the current PSP.
4. Assess individual notebooks to ensure they are being used as intended, and that their size is not too large for the notebooks to be useful.
5. Examine whether there are unnecessary documents in the individual notebooks.
6. Ensure communication books are accessible to individuals and that their inclusion in the individual notebooks does not hinder an individual's ability to communicate.
7. Determine if individual notebooks compete with staff's ability to reliably record data on problem behaviors.
8. Create adequate master records.
9. Complete the development of policies as described in provision item V2.
10. Incorporate recordkeeping activities into the facility's quality enhancement program, including ensuring the data collected by the

recordkeeping staff during their record audits are included in the QA program.

11. Include the individual records and master records in the audits done by the recordkeeping staff.

12. Develop a method to ensure that any needs or problems identified in the record audits are corrected.

13. Ensure records are used in making care, medical treatment, and training decisions. Determine a way to assess whether or not this is occurring.

14. Ensure SOAP nursing entries are done correctly and thoroughly.

The following are offered as additional suggestions to the facility:

15. DADS central office should consider whether or not to standardize the table of contents for the master records across SSLCs.

16. Use the information gathered from the staff survey on the use of records at the facility.

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	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
ADR	Adverse Drug Reaction
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFO	Ankle Foot Orthosis
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice A Day
BMD	Bone Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BPH	Benign Prostatic Hyperplasia
BS	Bachelor of Science
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BUE	Bilateral Upper Extremity
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Criminal Background Check
CBC	Complete Blood Count
CC	Cubic Centimeter

CCC	Clinical Certificate of Competency
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	centimeter
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
COTA	Certified Occupational Therapy Assistant
CPR	Cardio Pulmonary Resuscitation
CPW	Communication Picture Wallboard
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTD	Competency-based Training and Development
CV	Curriculum Vitae
CXR	Chest X-Ray
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DFPS	Department of Family and Protective Services
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DO	Doctor, Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
EENT	Eye, Ear, Nose, and Throat
e.g.	exempli gratia (For Example)
EGD	Esophagogastroduodenoscopy
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
FEET	Fun Exploring Environments through Training
FSPI	Facility Support Performance Indicators

FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Grams
GT	Gastro-tube
HCG	Health Care Guidelines
HIP	Head Injury Protocol
HMP	Health Maintenance Plan
HR	Heart Rate
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Status Team
HTN	Hypertension
I and D	Incision and Drainage
IBW	Ideal Body Weight
IC	Infection Control
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
INH	Isonicotinylhydrazine
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
KUB	Kidney, Ureter, Bladder
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LOD	Living Options Discussion
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MCG	Microgram

MD	Medical Doctor
MG	Milligrams
MMR	Measles, Mumps, Rubella
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Authority
MRA	Mental Retardation Associate
MS	Master of Science
MSN	Master of Science, Nursing
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NEO	New Employee Orientation
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
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
PA	Physician Assistant
P&T	Pharmacy and Therapeutics
PAP	Papanicolaou
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
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
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team

PO	By Mouth (per os)
POI	Plan of Improvement
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTA	Physical Therapy Assistant
QA	Quality Assurance
QAD	Quality Assurance Director
QE	Quality Enhancement
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDRR	Quarterly Drug Regimen Review
QID	Four times per day (quater in die)
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
ROM	Range of Motion
RPH	Registered Pharmacist
RR	Respiratory Rate
RTT	Rehabilitation Therapy Technician
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPO	Specific Program Objective
SSLC	State Supported Living Center
STAT	Immediately (statim)
T	Temperature
TB	Tuberculosis
TID	Three Times A Day
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone

UIR	Unusual Incident Report
URC	Unified Records Coordinator
UTI	Urinary Tract Infection
VNS	Vagus nerve stimulation
XR	Extended Release