United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: July 11-15, 2011

Date of Report: September 10, 2011

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

Methodology

In order to assess the facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review. **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(b) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

(c) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the facility.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.
g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

Executive Summary

First, once again, 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. The facility director, Jaime Monardes, was extremely supportive of the monitoring team's activities throughout the week of the onsite review. He was present throughout the campus, available as needed, and responsive to monitoring team requests.

The Settlement Agreement Coordinator, Helen Alvarez, was assigned a number of responsibilities for document preparation and coordination of activities during the onsite review. Unfortunately, many documents provided prior to, or in response to requests made during, the onsite review were inadequate, missing pages, or incorrect (i.e., documents different than what was requested were provided). This will need to improve for subsequent reviews at EPSSLC. Problems with documents are noted in a number of the provision reports below.

Second, management, clinical, and direct care professionals continued to be 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. Moreover, these discussions allowed for EPSSLC to demonstrate continued progress in many of the provision items. 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, as detailed in the full report below, EPSSLC had made progress in some areas, but a lot of work was still required in order for the facility to achieve substantial compliance in the many provisions of the Settlement Agreement. As the reader will see below, the requirements across provision items vary greatly. Some require full organizational system actions, whereas others only require the creation of a document or the hiring of qualified staff. Below are some comments on a few general topics that affected all areas of operation at the facility.

- Changes in senior management: EPSSLC had experienced numerous changes in senior management. At the time of this review, there was a new medical director (the third in three successive monitoring team onsite reviews), other new medical practitioners, a new incident manager, and an acting CNE. Moreover, the facility director, psychiatrist, QA director, APC, and HRO had been in their positions for only six months or so.

- Problems in physical and nutritional management and nursing care. These two areas will require considerable attention from facility management in order to meet generally accepted professional standards of care as well as substantial compliance with the Settlement Agreement. Concerns are detailed in sections M, O, and P below, but

included a lack of attention to PNM needs and activities of individuals, absence of appropriate nursing services, and problems with the readiness of emergency equipment. These concerns were further reflected in a letter from DOJ to DADS following the week of the onsite review. In response to comments from the monitoring team while onsite and in response to the concerns letter from DOJ, DADS put together a detailed action plan that included expert consultation to address these concerns.

- Integration of clinical services. Provisions G and H require the provision of integrated clinical services. Overall, these provisions were not being addressed in any organized or systematic way at EPSSLC resulting in an absence of integrated clinical services, even though there were some examples of integration occurring as noted in section G below. The Monitor recommends that the facility director take a large role in overseeing the facility's efforts towards complying with these two provisions. This is particularly important given that the medical director was new to the facility and to the state system. He was responsible for providing medical, developing and overseeing systems of health care, learning and following ICFMR regulations and Settlement Agreement provisions, and so forth. Moreover, the facility director might benefit from partnering with another SSLC facility director. Perhaps DADS central office can play a role in supporting this to occur.

- New projects: EPSSLC had initiated a number of new projects that had potential for improving services:
  - Engagement and activities pilot program
  - Streamlining of documentation and data collection requirements for direct care staff
  - QMRP facilitation skills: the monitoring team was very impressed with the set of QMRPs at the facility. They were engaging, knowledgeable, and very desirous of learning and improving their skills.

- Facility self-assessment: EPSSLC provided its facility self-assessment, called the POI. The development of a useful POI has been an ongoing project for all of the SSLCs. In each of the sections of this report, the Monitor comments on the POI. Overall, the EPSSLC POI described actions the facility had taken that, in its opinion, were moving the facility towards substantial compliance, and actions it planned to take in the future. While this information was useful to the monitoring team, the POI should describe
  - The activities the facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.
  - How the facility used the findings from these activities to determine substantial compliance or noncompliance.
  - A self-rating of substantial compliance or noncompliance.
  - Action steps/activities the facility planned to engage in to work towards substantial compliance.

- Staffing. The unit director reported that direct care staffing rates were improved, that is, fewer positions were vacant, there were many applicants for any open direct care positions, and there were fewer instances of understaffing.

- Monitoring tools. DADS central office had distributed self-monitoring tools that lined up with most provisions of the Settlement Agreement. These tools were meant to be more user-friendly and appropriate for use by facility staff than were previous versions. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below).

Fourth, 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

- EPSSLC showed continued progress towards substantial compliance. There was a reduction in the use of restraints since the last monitoring visit. Between 1/1/11, and 6/3/11, 69 restraints occurred. Of these, 51 (77%) were programmatic restraints, 50 (100%) of the programmatic restraints were physical restraints, 18 (23%) were emergency restraints, and 8 (44%) of the emergency restraints were physical restraints. None (0%) were mechanical restraints, and 10 (56%) were chemical restraints. Fourteen individuals were the subject of restraints.
- The facility, particularly the psychology department, had placed a significant focus on the individual with the highest number of restraints at the facility. According to psychology staff, this had been effective at reducing the number of behavioral incidents leading to restraints for the individual. Further, the behavior support plan format had been revised to provide better clarity to staff, competency based training had been developed for BSPs and Crisis Intervention Plans, a pilot program was implemented in Cottage 506 to increase active treatment and engagement levels, and restraint documentation was now being reviewed in daily Unit Meetings for completion and accuracy.
- There continued to be problems with accurate documentation and monitoring of restraints. The facility quality assurance process had identified these issues and had begun to address them.
- Not all individuals had PSPA meetings following more than three restraints in a rolling thirty-day period, and the PSPAs reviewed did not reflect an adequate review of the environmental, antecedent, and consequent variables that affected the behaviors that provoked restraint.

Abuse, Neglect, and Incident Management

- There was a decrease in the number of abuse and neglect allegations from FY11 1st quarter (32) to FY11 2nd quarter (27). The facility investigators conducted investigations for 15 additional serious incidents during the same time period. This included 12 serious injuries and 3 deaths.
- Investigation of 46 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility from 1/1/11 through 6/14/11. Of these 46 allegations, 2 (4%) were confirmed allegations by DFPS (including one allegation of abuse and one allegation of neglect), 23 (50%) were unconfirmed allegations, and 18 (39%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect and 3 were other (including pending).
- There were 775 injuries reported since 12/1/10. It should be noted that any time a nurse assessed for an injury, it was counted as an injury in the total number of injuries at the facility, even when there was no injury. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility.
- The facility implemented a number of procedures that were having a positive impact.
    - An Incident Management Coordinator had been hired. This freed up the facility's investigator to spend more time completing investigations while the Incident Management Coordinator could ensure follow-up actions were completed.
    - Incidents and injuries were being reviewed each day. These meetings appeared to be an effective way to ensure that documentation was completed for each incident and follow-up procedures were tracked and completed.
    - The facility planned to utilize the campus administrators as backup investigators. They were going through training.

Quality Assurance

- EPSSLC had made some, but not a great deal of, continued progress towards achieving substantial compliance. Improvement will be necessary in the key areas of this provision: QA policy, QA plan, QA data collection and analysis, QAQI Council, and the management of corrective actions.
- Progress was evident in two areas in particular. First, implementation and management of self-assessment monitoring tools for each of the Settlement Agreement provisions for which a tool existed (i.e., most, but not all) was regularly occurring. Second, the QAQI Council met regularly and had good attendance and participation. The group was discussing important topics, including the formation of work groups to attend to identified problems.

- QA policy and a QA plan were not yet developed. A QA report and a system of managing corrective actions were also not yet in place. Without these components, the facility was unable to thoroughly review, analyze, and summarize important data.
- QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, and conducted a variety of audits. Primarily, their time over the past few months was spent conducting reliability interobserver agreement reviews of each department's scoring of the self-assessment tools.

Integrated Protections, Services, Treatment, and Support

- Little progress was made towards compliance with this provision since the monitoring visit in January 2011. Compliance with section F 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.
- Three annual PSP meetings were observed by the monitoring team. QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. QMRPs had recently completed facilitation training and most were still adapting the meeting process to try to capture all information needed to develop a comprehensive plan.
- Information regarding supports that the individuals need throughout the day was more clearly stated in the newer PSPs. Adequate assessments were not always in place to ensure all necessary supports and services were integrated into the plan. 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 meaningful 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.
- Quality assurance activities with regards to PSPs were in the initial stages of development. Audit tools had been developed to determine if PSP meetings were being developed and implemented. This was a new process at the facility and action plans had not yet been developed to address findings.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- EPSSLC was not in compliance with these important provisions and was not yet taking serious action to address it. The medical director was the lead for these provisions, however, he joined the facility very recently and, therefore, it was not surprising that this was not his first priority, given the many other important medical service tasks to which he needed to attend. The monitoring team recommends that the facility director consider taking the lead for these provisions, G and H.
- Some specific examples were provided to, or observed by, the monitoring team that showed some ways in which clinical services were provided in an integrated manner. More so, however, there were a number of areas in which integrated services could be, but were not being, provided.
- A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility.
- It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of this provision.

At-Risk Individuals

- The at-risk process underwent significant revision, designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance.
- EPSSLC had taken minimal steps towards compliance with this provision including:
    - 90% of employees had attended webinar training on the at risk policy in February 2011.
    - Implementation had begun of the new risk action plan for individuals determined to be at risk. Health care plans were being developed from the risk action plans.
    - Risk levels were being entered into the statewide database.
- The monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual.

Psychiatric Care and Services

- Psychiatry services at EPSSLC made continued progress towards substantial compliance. The psychiatry department had seen continued improvement with designated space provided for clinic, and administrative assistance. The clinic was more organized, the psychiatrist received clinical information during clinic, more staff were in attendance at clinic, and discussions regarding the individuals were more detailed.
- 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 physician was not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, made medication additions or adjustments in absence of data regarding specific target symptoms. 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.
- Nevertheless, there were several areas where the facility was close to achieving substantial compliance ratings (e.g., J15, J12, J4), however, in other areas, while isolated improvements were seen, the facility staff must create a system for the provision of psychiatric services. Approaching this section as an isolated task list will not achieve the desired results, instead, a comprehensive, collaborative, integrated psychiatric service is required.

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 continued progress in several areas. These included the abandonment of the practice of paging the psychologists whenever a behavioral outburst occurred, all psychologists were enrolled in coursework for board certified behavior analyst (BCBA) certification, expansion of the data collection system, the establishment of a method for collecting and tracking objective measures of data reliability, and the establishment of treatment integrity. Also, the continued development of goal directed psychological therapies with measurable objectives and treatment expectations, and the development of a protocol for the training of the implementation of Positive Behavior Support Plans were other areas of improvement.
- The areas that the monitoring team suggests EPSSLC focus on for the next onsite review are to ensure that DCS staff are trained and data are reliable, and that all treatment decisions are data-based. The psychology department should also provide support in the form of appropriate data collection and presentation of data, to foster data-based decisions for other departments (e.g., psychiatry, habilitation services), provide technical support to other departments (e.g., program developers, dentistry) to ensure that they correctly and effectively

utilize the principles of applied behavior analysis, and ensure that the newly developed treatment integrity system is consistently used throughout the facility, that data are regularly tracked and maintained, and that minimal acceptable integrity scores are established.

Medical Care

- The medical department had made essentially no progress since the previous visit and many of the initiatives that were underway in January 2011 had not moved forward. This was due, in large part, to both of the primary providers working just a few months at the facility. The new medical director was just becoming familiar with the facility, its operations, and the requirements of the Settlement Agreement. As would be expected, many aspects of the Settlement Agreement were not familiar to him.
- While individuals received basic care, there were significant issues related to the provision of preventive care and transitioning individuals into acute care. Those aspects of this review that required data from the facility were seriously impeded by a lack of good data. In many instances, the monitoring team was informed that data did not exist. In other instances, data were provided that were not adequate.
- The external medical review was completed in May 2011. This review consisted of six chart audits. Corrective action plans resulting from that process were in the process of being completed. Mortality reviews were completed, albeit completion was 10 months following death for two individuals. It was encouraging to note, however, that the facility identified systemic issues in the reviews and implemented corrective action plans.
- There was no formal medical quality program and no steps had been taken to assess the quality of medical care provided independent of the external review. The medical director reported that he was developing a template for an internal review. The medical department had not implemented any new policies or procedures since that last review and the state issued clinical guidelines had yet to be released.

Nursing Care

- As of the current review, because the CNE was out on leave, the NOO was the Acting CNE. In addition, two RN positions were transferred to other departments, there was a significant increase in unscheduled absence and use of voluntary and mandatory overtime, and there was an elimination of the Nurse Educator, Hospital Liaison, and Nurse Recruiter positions in the department.
- The good news was that the nursing leadership had held fast to their commitment to improve nursing care for the individuals, and they tried to continue to move forward toward achieving the provisions of the Settlement Agreement. They had continued to closely collaborate with the Director of the Pharmacy and the Quality Assurance Nurse. As a result of their continued hard work and collaboration, there continued to be improvement in performance and progress toward the achievement of provision M6.

- Notwithstanding these positive findings, there were many problems in nursing care. For example, nurses failed to consistently perform complete assessment of individuals with significant changes in their health and failed to ensure timely and appropriate care and treatment. Egregious violations of infection control were observed, and, across the facility, the emergency medical equipment was in complete and total disarray.
- Also, nurses were woefully unprepared during individuals' interdisciplinary meetings. These lapses resulted in delayed assessment and planning to address individuals' health risks and delayed implementation of at least one individual's plan to transition from enteral to oral feeding.
- There were many more findings and areas where nursing care had not met standards of practice and where progress toward compliance had not occurred and may have actually declined.

Pharmacy Services and Safe Medication Practices

- Continued progress was noted in several areas. The pharmacy continued to document interventions between pharmacists and prescribers. It was not clear if the pharmacists and medical staff were compliant with the requirements for severe drug interactions. Incomplete physician orders appeared to be a problem and notification of the medical staff did not result in any appreciable change in prescribing patterns.
- The Quarterly Drug Regimen Reviews were thorough and provided the medical providers with good information and reasonable recommendations. The response of the medical staff to recommendations of the QDRRs, and the MOSES and DISCUS evaluations, presented a challenge. Documents frequently showed nothing more than a signature.
- Adverse drug reaction reporting increased and the data were being used to assess other components of medication practices at the facility. The current policy lacked a threshold for intense review. This was needed to ensure that serious, but non-reportable reactions received appropriate attention. DUEs were completed on a monthly basis, although it appeared that some of these provided little information to the facility.
- Many steps had been taken to address the problem of medication variances. Numerous systems changes had been implemented. Bin returns decreased and reconciliation rates increased. Even so, significant problems remained such as the overages and shortages associated with the liquid medications. Implementation of systems changes related to liquid refills appeared early on to have an impact on the overage/shortage issue.

Physical and Nutritional Management

- The PNMT at EPSSLC was not fully constituted. Alternate nursing participation had been accomplished via attendance at the meetings by a variety of RN Case Managers. PNMT members had previously struggled with their dual role as clinical PST member and PNMT member. This continued to be an issue as demonstrated by the meeting conducted during this onsite visit. Though the PNMT had been encouraged during the previous review to be more proactive in identifying individuals who would benefit from PNMT assessment, only five individuals

had been assessed since October 2010. There had been no new evaluations initiated since January 2011 until one for Individual #191 during the onsite review week. The PNMT conducted no systems review of individuals who had been hospitalized or identified with high risk indicators who may have required PNMT review and intervention.

- Documentation of the PNMT meetings showed that the discussion was largely anecdotal rather than data-driven and action oriented. It would be difficult for anyone to track data collected, clearly identify the clinical reasoning process used by the team, recognize specific actions planned, or taken or to determine if interventions were effective to mitigate the presenting concerns that required PNMT assessment and review in the first place.
- Of significant concern was the status of PNM staff training specifically related to mealtime. This training was observed during this week. The training by professional staff was poorly presented. Content and handouts were not appropriate for direct support staff. While some improvements were noted in the Dorm area during mealtimes, the NEO training did not provide a solid foundation upon which to build knowledge and skills for individual-specific training of Dining Plans. Further, staff were not confident in their understanding of why specific supports were needed and individual risks indicators of the individuals for whom they were responsible. The current training must be immediately abandoned for a well-designed curriculum with appropriate content, instructional methods, and materials.
- Given this, there continued to be serious problems with the lack of repositioning before meals, and staff implementation of mealtime supports in 513 continued to be problematic as noted in every previous onsite review. There was no self-correcting system in place to address the issues noted in this home and, thus, the same errors continued to occur and re-occur.
- Overall progress toward substantial compliance with this element was disappointing. On several counts the accuracy of information provided to the monitoring team by the Habilitation Therapies Director was questionable. Clearly any progress made to date was by virtue of the therapy clinicians themselves and not to any direction or strategic planning from him. There were no directed initiatives.
- Even so, there were very strong, hard working PNM direct service clinicians at EPSSLC and for the most part, they appeared to work well together. There were several highlights:
    - Karin De La Fuentes worked with the PSTs to review individuals with regard to enteral nutrition and a number of these were currently progressing with the successful transition to oral intake.
    - The monitoring team's previous concerns for Individual #93 related to position, alignment, and support during meals had been addressed.
    - There were fewer errors in the provision of diet texture and liquid consistency, particularly in the Dorm area.

Physical and Occupational Therapy

- The OT and PT staff were strong clinicians who worked well together and strived to improve the delivery of supports and services at EPSSLC. Staffing for OT had increased significantly.
- Assessments were improving with efforts to begin to link the health risk assessment process to the OT/PT assessment process and in the development of the PNMP. The focus continued to be primarily on health risk, though there were notable efforts to address functional skill acquisition. Most of the goals established were measureable, but the performance criteria were lacking in that it was not clearly stated how it would be known that learning had occurred.
- Meaningful and functional learning opportunities must be recognized as equally important as physical health concerns and that independence, engagement and participation are also critical to positive health outcomes for individuals. Greater consideration for actual potentials for participation was indicated. In some cases it was determined that individuals did not have potential for skill acquisition due to the fact that they were functioning at baseline, suggesting that the only rationale for intervention was regression.
- Though equipment generally was available, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standard of care. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. The NEO session related to transfer instruction was observed during the week of this review and was very well organized with excellent instructional methods used by the PTA and COTA trainers. It was noted and brought to the attention of the instructors that it was critical that staff be required to follow through with each transfer to finish with properly aligning the individual. In most of the practices, staff were released as soon as the model was placed in the chair.
- It was of concern to the monitoring team that in some cases PNM supports and services identified as necessary for an individual were not provided due to the lack of sufficient staffing.

Dental Services

- The dental department continued to make small incremental gains in progress in some areas. A new database was implemented to allow for collection of data to determine progress within the department. This database provided information that was not previously readily available. While the facility was providing significant preventive services, there appeared to be a lack of other care, such as restorative services and x-rays.
- A troubling finding was the data reported on oral hygiene status which indicated that approximately 40% of individuals had poor oral hygiene. Several steps had ben taken to address oral care provided in the homes, but a lack of quarterly hygiene ratings did not allow for determination of overall interval improvements.
- Overall, it appeared that annual assessments were being completed in a timely manner, but data integrity issues made it impossible to determine an accurate compliance rate. The facility reported no missed appointments and

no shows. This was largely due to the commendable efforts of the two hygienists who frequently escorted individuals from home to the clinic.

- Several individuals were identified as needing desensitization plans. The plans as developed by the psychology department were not based on the individual needs of the individuals who required the plan. Further, most plans had not been implemented and requests for updates were not fulfilled.

Communication

- There was limited progress noted since the previous review, though it was evident that the speech clinicians were extremely busy with assessments and attempts to organize their approach to achieving substantial compliance. As previously noted, a focus on engagement in functional activities designed to promote actual participation, making requests, choices and other communication-based activities, using assistive technology, was a critical priority. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts.
- The SLP Master Caseload and Priority Plan was only an outline of items for two different time periods and it was not clear how these were related. There were no clear statements of how individuals would be prioritized for the completion of comprehensive communication assessments.
- As a result of some assessments, communication books were discontinued because they were deemed to be inappropriate or non-functional, though in some cases, there was nothing provided as an alternative. Further, it appeared that the new assessments were not resulting in additional supports related to AAC and communication. There were a small number of community-based systems finally mounted after they had been pending nearly one year ago, however, staff indicated that they had only been installed weeks prior to this onsite review.
- There were seven individuals listed as receiving direct speech services, but no current SPO or related documentation for interventions was submitted for review. There was no evidence of routine contact, review, and intervention with the individuals identified as receiving these services.

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, the monitoring team noted several improvements since the last review. These included modifications to the skill acquisition training

sheet/format, expansion of the training methodology, initiation of graphing of skill acquisition data, and continued focus on improving individual engagement in selected cottages.

- The monitoring team believes that the facility should focus on the following over the next six months on ensuring and documenting that SAPs are meaningful to each individual (e.g., based on documented need and preference), that the continuation, modification, or discontinuation of SAPs are the result of data-based decisions, that the SAPs are implemented with integrity, and the continued improvement of individual's engagement by focusing on one cottage at a time.

Most Integrated Setting Practices

- EPSSLC had not made much progress in meeting the provision items of T1. The facility, however, did continue to progress in meeting the provision items of T2. The lack of progress in T1 was most evident in the delayed, slow, and/or lack of activity taken to support, encourage, and assist individuals to move to the most integrated setting, especially once an individual was referred. The specific numbers of individuals who were placed and who were in the referral and placement process remained low, given the size of the facility.
- The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document.
- The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and his staff work closely with the QMRP coordinator and the QMRPs to ensure this get implemented correctly. There was wide variability in the amount of information included in the PSPs within each subsection of the LOD.
- Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability).
- Little work was done to educate individuals, their family members and LARs, and staff about the variety of community living and working options that might be available to individuals.
- Only two completed CLDPs were available for review during the onsite review. The lists of essential and nonessential supports in the CLDP focused primarily on the provision if inservices and the scheduling of appointments. There were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns.

- DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. As this develops, the APC and QA department need to ensure that they are looking at quality of the items on their tool, not just their presence (see Facility Self-Assessment above).
- Post move monitoring (T2a) was rated as being in substantial compliance. The PMM's reports were very detailed and indicated that she observed and followed up on more than only what was specified in the CLDP. For example, rather than only monitoring whether an inservice occurred or an appointment was made, she conducted observations, interviews, and document reviews to look at implementation and competency of implementation.

Consent

- Some positive steps that the facility had taken in regards to consent and guardianship issues included the development of a list of individuals considered high priority for guardianship, and a list of guardianship providers in the El Paso area. Local resources for obtaining advocates were explored by the facility's staff.
- Even so, while the facility maintained a list of some individuals needing an LAR, not all individuals had been assessed and not all PSTs were adequately addressing the need for a LAR or advocate and, further, little activity or planning to solicit guardians for those determined to be in need had occurred.
- 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 Practices

- EPSSLC had made continued progress towards achieving substantial compliance with the items of this provision. Moreover, the medical records coordinator and the unified records coordinator were responsive to many of the recommendations and suggestions made in the previous monitoring report.
- One of the their major accomplishments were the creation of a master record for each individual. Another was the regular implementation of five audit reviews of all three components of the unified record each month, and the recent initiation of feedback to managers and clinicians regarding any errors that were identified. Another was ongoing training and refresher sessions for all staff.
- The active records and individual notebooks were organized according to the required format, however, many were not as neat, thinned, or repaired as they should have been. This was most likely due to there being many different staff who were involved in filing and thinning (e.g., house supervisors, clinicians, overnight staff). Other areas for improvement were ensuring that all medical consultation documents were in the active record and that entries in the integrated progress notes were legible, with a legible signature, and with the clinician's credentials included.

- A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. The facility indicated, on a spreadsheet, that status of the state and facility policies, however, EPSSLC did not appear to be following the state office's expectations for facility-specific policies.
- Thorough reviews of all three components of the unified record were conducted by the unified records coordinator. Items needing correction were noted in the comments column of the review tool. A systematic way to provide PST members with feedback on corrections that were needed (e.g., missing documents, out of date documents) was not yet in place.
- EPSSLC had taken some steps towards ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4, including ensuring records were present at PSP meetings, conducting interviews of PST members, and increasing their skill at recognizing appropriate SOAP entries in the IPNs. More guidance is expected from central office over the next few months.

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.

II. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o EPSSLC Policy: Use of Restraint Policy dated 4/28/11 o List of all restraints used for crisis intervention for the past six months o List of all chemical restraints for the past six months o EPSSLC Restraint Audits 1/1/11 – 5/31/11 o EPSSLC Restraint Trend Analysis for FY11 o List of individuals with dental desensitization plans o EPSSLC Plan of Improvement o Restraint Reduction Committee meeting minutes since 1/1/11 o List of all individuals who had a Safety Plan o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum o Training transcripts for 24 EPSSLC employees o Sample of Daily Incident Review Team Meeting Minutes o Dental desensitization plans for Individual #65, Individual #169, Individual #53, Individual #27, Individual #92, Individual 74, Individual #117, Individual #25, and Individual #18 o PSPs for Individual #161, Individual #61, Individual #102, Individual #104, Individual #31, and Individual #37 o Restraint Audits for: Individual #13 (4/19/11 and 1/10/11), Individual #161 (4/28/11), Individual #8 (4/16/11), Individual #102 (4/29/11), Individual #38 (4/19/11), and Individual #81 (3/6/11 and 4/9/11) o A sample of restraint documentation for medical restraints including: • Individual #99 dated 5/5/11 • Individual #23 dated 4/8/11 • Individual #56 dated 4/20/11 • Individual #116 dated 4/12/11 o Positive Behavior Support Plans (PBSPs), PSPAs, and Safety Plans for: • Individual #109, Individual #81, Individual #39, Individual #13

- A sample of restraint documentation for behavioral intervention including:
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Individual	Date/Type	Restraint Checklist and Face to Face Assessment	PSP Addendum (A)	PBSP	Safety Plan
#81	5/9/11 Physical	x	11/1/10 1/21/11 (A)	12/10	12/10
	5/7/11 Physical	x			
	3/6/11 Physical	x			
	1/3/11 Physical	x			
#39	5/25/11 Physical	x	5/19/10 6/2/11 (A)	6/17/11	5/18/11
	5/9/11 Physical	x			
	3/21/11 Physical	x			
	2/10/11 Physical	x			
#13	6/10/11 Physical	x	3/14/11 6/6/11 (A)	4/1/10	1/11
	5/24/11 (2) Physical	x			
	5/10/11 Physical	x			
	3/21/11 Physical	x			
	2/28/22 Physical/Chemical	x no FTF			
	1/28/11 Physical	x			
	1/15/11 Physical	x			

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

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Mario Gutierrez, Incident Management Coordinator
- Michael Reed, Lead Investigator
- Cynthia Martinez, QMRP Coordinator
- Gloria Loya, Human Rights Officer
- Valerie Grigg, Director of Behavioral Services
- Carmen Molina, Psychologist

<u>Observations Conducted</u>:

- Observations at residences and day programs
- Morning Unit Meeting 7/11/11 and 7/14/11
- Incident Management Review Team Meeting 7/12/11 and 7/14/11
- Human Rights Committee Meeting
- Annual PSP meetings for Individual #5 and Individual #43

	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The facility's Plan of Improvement for section C indicated that the facility had implemented several new processes to address deficiencies noted in the last monitoring report. These processes are discussed below in regards to meeting compliance for each provision in section C. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility was aware of problems with monitoring and documentation of restraints, and was in the beginning stages of addressing those issues. The facility rated itself as being in substantial compliance with items C1 and C2. The monitoring team did not find the facility to be in substantial compliance with item C1, but did find that the facility was in substantial compliance with C2. The monitoring team also agreed with the facility's self assessment rating on noncompliance for items C3 through C8. Positive steps taken to address noncompliance by the facility are noted in the summary section. The facility POI indicated that the facility had begun reviewing restraint incidents and documentation of those incidents daily at Unit Meetings. Two of these meetings were observed during the monitoring visit. These meetings should be an effective way to identify problems with restraint application and documentation. The facility needs to ensure that a process is in place to identify and address trends or systemic issues in regards to restraint application, monitoring, and documentation.
	Summary of Monitor's Assessment: EPSSLC showed continued progress towards substantial compliance with the items of this provision. Based on information provided by the facility in a list of all restraints used for crisis intervention, between 1/1/11, and 6/3/11: • 69 restraints occurred; • 51 (77%) were programmatic restraints; • 50 (100%) of the programmatic restraints were physical restraints; • 18 (23%) were emergency restraints; • 8 (44%) of the emergency restraints were physical restraints; • 0 (0%) were mechanical restraints; • 10 (56%) were chemical restraints; • 14 individuals were the subject of restraints.

	There had been significant reduction in the use of restraints since the last monitoring visit when it was reported that 22 individuals had been the subject of 192 restraints. The facility, particularly the psychology department, had placed a significant focus on the individual with the highest number of restraints at the facility. According to psychology staff, this had been effective at reducing the number of behavioral incidents leading to restraints for the individual. According to the facility POI, action taken by the facility to address compliance with section C since the last monitoring visit included: • Behavior support plan format had been revised to provide better clarity to staff. • Competency based training had been developed for BSPs and Crisis Intervention Plans • A pilot program was implemented in Cottage 506 to increase active treatment and engagement levels. • All staff were in-serviced on restraint prevention and documentation of restraints. • Restraint documentation was now being reviewed in daily Unit Meetings for completion and accuracy. As noted throughout section C, there continued to be problems with accurate documentation and monitoring of restraints. The facility quality assurance process had identified these issues and had begun to address them. Not all individuals had PSPA meetings following more than three restraints in a rolling thirty-day period, and the PSPAs reviewed did not reflect an adequate review of the environmental, antecedent, and consequent variables that affected the behaviors that provoked restraint. It is recommended that PSPA meetings consistently occur following more than three restraints in a rolling thirty-day period, and that these meetings be organized so as to ensure that each of the issues below are discussed and documented. Finally, 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 (when practical and possible) for behaviors that provoke restraint have been developed, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent).

#	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	<u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training, that 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 for review of restraints resulting from behavioral incidents. This included a random sample of restraints for the three individuals with the highest numbers of restraint. The individuals in this sample were	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Individual #81, Individual #39, and Individual #13. • Individual #13 had the greatest number of restraints, accounting for 31 (45%) of the 69 restraints for crisis intervention since 1/1/11. • Individual #39 had the second greatest number with 9 (13%) of the restraints. • Individual #81 had the third greatest number with 8 (12%) of the restraints. • These three individuals accounted for (70%) of all the restraint incidents. An additional sample, referred to as Sample #C.2, was selected for review of restraint documentation resulting from restraints used for medical care. This included a random sample of four restraints for four individuals: Individual #99, Individual #23, Individual #56, and Individual #116. Based on a review of 16 restraint records for individuals in Sample #C.1 involving three individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> Based on document review, the facility policies stated 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 16 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 16 of the 16 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • Aggression towards staff and/or peers, self-injurious behavior, and property destruction was indicated as the reason for the restraint on all forms that described behavior leading to the event. • For the 16 restraint records in the sample, a review was completed of <u>the description of events leading to behavior that resulted in restraint</u>. A majority of the checklists reviewed described the individual's behavior prior to the restraint, but not all described events leading up to or causing these behaviors. Three of the checklists (19%) 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. Restraint checklists that gave a brief description of events leading to the behavior included: restraints for Individual #13 on 1/28/11; restraint for Individual #39 on 5/25/11; and restraint for Individual #81 on 5/9/11. Examples of good documentation included:	

#	Provision	Assessment of Status	Compliance
		o The restraint checklist for Individual #81 dated 5/9/11 indicated that the individual became aggressive after he returned from an outing and was directed to go take his medication. o The restraint checklist for Individual #39 dated 5/25/11 indicated that he began throwing objects at peers and staff when peers were being loud. o The restraint checklist for Individual #13 dated 1/28/10 indicated that he was upset because he could not find his ball. He began throwing rocks at staff. Examples where this was not the case included: o In the area for the description of events on the restraint checklist for Individual #13 on 5/24/11, staff documented "he was placed in a horizontal restraint. He started to kick and punch staff saying to go home." o On the restraint checklist for Individual #178 dated 10/11/10 the description of events leading to the behavior noted "was being aggressive throwing items, banging his head against the wall, pulled cover off light fixture in his room." Staff did not document in what activity the individual was involved prior to the incident. • In 16 of the records (100%), staff documented 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. 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. It was not evident that restraints were not used in the absence of or as an alternative to appropriate programming and treatment. As noted above, documentation did not always indicate what activities individuals were involved in prior to restraint. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 16 restraints, 16 (100%) were documented as approved restraints techniques.	

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		Dental/Medical Restraint The facility provided a list of medical pretreatment sedation/ medical restraints between 12/1/10 and 4/20/11: • 29 individuals were the subject of restraints, • 29 incidents of restraint occurred, • 26 of these were dental restraints for treatment; • Three were medical restraint for routine appointments. • Six individuals had dental desensitization programs in place. The facility's POI indicated that "Prohibition of prone restraint" posters had been put in all cottages and dorms. These posters were observed in all residential and day programs. The POI did not indicate what other measures had been taken to address this provision. The facility was not in compliance with this provision item. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint and document all interventions attempted prior to restraint. Further, as noted throughout this report, it was not evident that adequate treatment and programming was being consistently implemented that might reduce the number of behavioral incidents leading to restraint.	
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 three individuals in Sample #C.1 were reviewed. Of these, all three of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint. • For Individual #13, his SPCI did not describe indicators for when staff should attempt release from restraint. • Individual #39's SPCI included instructions to release him from restraint when he was calm (no struggling, no yelling) for at 10 seconds. It further instructed that release must be attempted on or before 10 minutes. • The SPCI for Individual #81 stated that he should be released when he deescalates in the manner of overall decrease of struggling against the restraint, yelling, and biting. A sample of restraint documentation for physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Sixteen (100%) restraints of 16 reviewed indicated that the individual was released immediately when no longer a danger or when he met the conditions of the SPCI. Restraints in the sample lasted from 10 seconds to 15 minutes in duration. The facility POI indicated that all staff members were trained on restraint prevention and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		use using competency based measures. The facility had self-rated C2 as being in substantial compliance. The monitoring team agrees with this assessment, however, SPCIs should describe behavioral indicators specific to each individual that would allow staff to consistently determine when the individual is no longer an immediate risk to him/herself or others. See section C7 for additional comments regarding the adequacy of SPCIs.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 included 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. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • Twenty-three (96%) had current training in RES0105 Restraint Prevention and Rules. • Seventeen of the 23 (74%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • Twenty-three (96%) had completed PMAB training within the past twelve months. • Twenty of the 23 (87%) completed PMAB refresher training within 12 months of previous restraint training. The facility POI indicated that the facility had a 99% compliance rating in regards to PMAB training. This was not confirmed by the sample of employee training records reviewed. The facility is not in substantial compliance with this provision item. Employees will need to complete retraining annually as required by the facility policy to gain substantial compliance with C3.	Noncompliance
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	Based on a review of 16 restraint records (Sample #C.1), 16 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures.	Noncompliance

#	Provision	Assessment of Status	Compliance
	restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The facility had not developed medical desensitization plans for individuals who required the use of restraint for routine medical care. Dental desensitization programs had been developed for 10 individual who needed pretreatment sedation or restraint to have work completed. The desensitization plans, however, were not individualized. The facility did not maintain a "Do Not Restrain" list. Each individual's PST should discuss risk associated with restraint for the individual based input from PNMT and medical staff. A list of individuals for whom restraints would be contraindicated due to medical or physical conditions should be developed and maintained by the facility. For example, PSPs for individuals at risk for aspiration or fractures should clearly state that the individual should not be physically restrained or offer clear guidelines for safely restraining the individual. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed that include individual specific strategies to try to reduce or eliminate the need for restraint. The facility is not in compliance with this provision. The facility POI also indicated that the facility was 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 start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary	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 16 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 15 out of 16 incidents of restraint (94%), there was assessment by a restraint monitor. o There was not an assessment by the restraint monitor for Individual #13 on 2/28/11 • In 14 out of 15 instances of physical restraint (93%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o The restraint assessment for Individual #39 dated 5/25/11 did not indicate what time the assessment was completed. • In 15 instances (94%), the documentation showed that an assessment was completed of the application of the restraint. • In 15 instances (94%), the documentation showed that an assessment was completed of the circumstances of the restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of 16 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 restraint in 10 (63%) of the instances of restraint. Restraint records where this did not occur as required included: o Individual #81 was restrained at 1:25 pm on 1/3/11. According to the restraint checklist, he was not assessed by a nurse until 4:00 pm. o Monitoring by a health care professional was not documented for Individual #39 during a 15 minute restraint on 3/21/11, o Individual #39 was restrained at 1:45 pm on 2/10/11. The nurse did not assess his vital signs or mental status until 4:32 pm. o The nurse did not document the time of assessment on the restraint checklist dated 5/24/11 for Individual #13. o Individual #13 was restrained at 2:19 pm on 5/10/11. According to the restraint checklist, he was not assessed by a nurse until 3:10 pm. o Individual #13 received a chemical restraint at 6:30 pm on 2/28/11. He was not monitored by a health care professional every 30 minutes as required. o Another restraint for Individual #13 on 6/10/11 indicated that the nurse did not monitor his vital signs or mental status until over an hour after the restraint was initiated. • Monitored and documented vital signs in 14 (%). o The nurse did not document vital signs were checked for Individual #81 following a restraint on 5/7/11. o Vital signs were not documented for Individual #39 on 3/21/11. • Monitored and documented mental status in 15 (98%). o Mental status was not documented for Individual #39 on 3/21/11. Based on a review of four pretreatment sedation for medical restraint records, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint for a minimum of two hours in two (50%) of the instances of restraint. Restraint records where this did not occur as required included: o for Individual #99 on 5/5/11, o for Individual #56 on 4/20/11, • Physician orders were written for the use of the chemical restraint in four of four (100%) records, • And physician orders specified the frequency of monitoring in zero (0%) records.	

#	Provision	Assessment of Status	Compliance
		The facility's POI indicated that steps taken to address noncompliance with this provision included: • Unit meetings began and addressed all restraints that happened the day previous. Documentation was reviewed and follow-ups were assigned and stay on the agenda until the follow-up was completed. • All nurses completed competency based training restraint guidelines and documentation. Not all restraints were being monitored as required by this provision. Some of the restraints that did not indicate adequate monitoring by a nurse occurred after competency based training was completed by nursing staff. Monitoring and post restraint review should be consistently documented on the restraint checklist. The facility rated itself as noncompliant with this provision due to errors in documentation and monitoring. 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 documented consistent with	A sample of 16 Restraint Checklists for individuals in non-medical restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 16 (100%), continuous one-to-one supervision was indicated as having been provided. • In 16 (100%), the date and time restraint was begun were indicated. • In 16 (100%), the location of the restraint was indicated. • In 3 (19%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Thirteen did not indicate what events were occurring that might have led to the behavior (see section C1 for a list of exceptions). • In 16 (100%), the specific reasons for the use of the restraint were indicated. • In 14 (88%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. The exceptions were a restraint for Individual #39 dated 5/25/11 and Individual #13 dated 5/24/11. • In 15 (94%), the names of staff who applied/administered the restraint was recorded. The restraint checklist for Individual #13 only listed one staff person who applied a horizontal restraint on 5/24/11. If administered appropriately, another staff person would have been involved. • Observations of the individual and actions taken by staff while the individual was in restraint for 16 physical restraints were recorded. • In 16 (100%) of physical restraint incidents, the date and time the individual was released from restraint was indicated. • In 15 (94%), the results of assessment by a licensed health care professional as	Noncompliance

#	Provision	Assessment of Status	Compliance
	Appendix A.	to whether there were any restraint-related injuries or other negative health effects were recorded. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. In a sample of 16 records (Sample #C.1), restraint debriefing forms had been completed for 15 (94%). The exception was for a restraint involving Individual #13 on 2/28/11. A sample of four individuals subject to medical restraint was reviewed and in two (50%), there was evidence that the monitoring had been completed as required. See section C.5 for details of this finding. The facility's POI indicated that the following actions had been taken to meet compliance with item C6. • A poster outlining nursing responsibilities during restraint was placed in each cottage and dorm. • All nurses were trained on restraint guidelines and documentation. Competency based measures were used. The facility's self assessment indicated that the facility was not in compliance with section C6. The monitoring team agrees with this finding. Monitoring of restraints as required should be documented on the restraint checklist for each restraint incident. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. As noted in the review of documentation above, the facility was not in compliance with the requirements of this provision item.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to EPSSLC documentation, during the six-month period prior to the onsite review, a total of four individuals were placed in restraint more than three times in a rolling thirty-day period. All four of these individuals (i.e., Individual #13, Individual #39, Individual #109, and Individual #81) were reviewed (100%) to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, functional	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessments, and personal support plan addendums (PSPAs) that occurred as a result of more than three restraints in a rolling thirty-day period were requested for all four individuals. Functional assessments were not available for any of the individuals, and PSPA minutes were only available for Individual #39. The results of this review are discussed in sections C7a through C7g. Individual #39's PSPA of 5/2/11 reflected a conversation concerning his lack of skills to effectively communicate his wants and needs. The PSPA also reflected an action plan that consisted of the psychology department developing a plan to improve Individual #39's communication skills. This represented a good example of a PSPA that achieves compliance with this item because it documented a discussion of a potential deficit in an adaptive skill (i.e., communication) that affected a dangerous behavior that provoked restraint, and a plan to address the adaptive deficit. This item was rated as in noncompliance because a PSPA following more than three restraints was only available for one of four (25%) individuals reviewed. Each individual who has more than three restraints in a rolling thirty-day period should have a PSPA meeting, and minutes from that meeting should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(b) review possibly contributing environmental conditions;	Individual #39's PSPA reflected a discussion of noisy environments as a possible contributing environmental factor to his dangerous behavior that provokes restraint. No suggestions, however, for reducing noise to prevent the future probability of restraint were documented in Individual #39's PSPA minutes. All PSPAs should reflect a discussion of possible contributing environmental factors, and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item is concerned with a review of potential antecedents to the behavior that provoke restraint. The one available PSPA did not document a discussion of antecedent conditions that may increase the probability of dangerous behavior that provokes restraint. Examples of issues that could be discussed here would be the role of antecedent conditions such as the presence of demands or novel staff on the behavior that provoke restraint. This discussion should also include how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed) to decrease	Noncompliance

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		the future probability of the dangerous behavior.	
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. Individual #39's PSPAs did not document a discussion of variables that may be maintaining the dangerous behavior that provokes restraint. Possible functions of dangerous behavior that could be discussed here are escaping demands or accessing staff attention. 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.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	All four individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Four (100%) were based on the individual's strengths; • Three (75%) of the PBSPs reviewed (Individual #109 was the exception) specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors) ; • All four (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 four plans); and • All four (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. None of the four PBSPs (0%) 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 four Safety Plans of the individuals in the sample were reviewed. The following represents the results: ▪ In all four of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In one (Individual #39) of the four of the safety plans reviewed (25%), the maximum duration of restraint authorized was specified; • In all (100%), the designated approved restraint situation was specified; and • In all of the safety plans reviewed (100%), the criteria for terminating the use of the restraint were specified	Noncompliance

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	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%) was integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	There was evidence that for at least one (i.e., Individual #13) of the individuals reviewed, PBSPs were modified (when necessary) to decrease the future probability of him requiring restraint.	Substantial Compliance
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.	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, Incident Management Review Team Meeting (IMRT) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Observation of the IMRT meeting confirmed that restraint incidents were reviewed by the team. Restraint incidents were referred to the PST for follow-up. PSTs met following restraint incidents to review restraints. A sample of Face-to-Face Debriefing and Review Form related to 16 incidents of non-medical restraint for was reviewed by the monitoring team. The review form had an area for signature indicating review by the Unit Director and the Incident Management Team. • In review of 16 restraint review forms for sign off by the Unit Director and IMC Designee, 0 (0%) were reviewed by either the Unit Director and/or the IMC Designee. As noted throughout Section C, restraint documentation contained errors in documentation and monitoring. None of the Restraint Review forms in the sample addressed errors or incorrect procedures in documentation, application, or monitoring of the restraint. The facility had implemented a quality assurance process to monitor restraints. Reviewers were utilizing a tool developed by the state office based on requirements of Section C of the Settlement Agreement. Findings were similar to the findings in this report. In the sample reviewed by the facility, there were problems noted in documenting events leading to the restraint and nursing assessments.	Noncompliance

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		The facility POI indicated that restraints were being reviewed in unit meetings. Documentation was reviewed, follow-up was assigned, and it stayed on the agenda until the follow-up action was completed. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation.	

Recommendations:

1. A list of individuals for whom restraints would be contraindicated due to medical or physical conditions should be developed and maintained by the facility. (C1, C4)

2. Employees will need to complete retraining annually as required by the facility policy. (C3)

3. The facility needs to ensure all individuals are monitored during and following restraints as required and clearly documented on the restraint checklist for each restraint incident. (C1, C5, C6)

4. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. (C1, C2, C6)

5. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint. (C4)

6. 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. (C8)

7. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation. (C8)

8. Behavior support plans should be reviewed and revised when strategies are not effective for reducing the number of restraints implemented. (C1, C3, 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 EPSSLC Policy: Incident Management, updated 4/29/11 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 updated 5/11/11 o Information used to educate individuals and LARs on identifying and reporting unusual incidents. o Incident Management Committee meeting minutes for each Monday of the past six months o Sample of Unit Level Meeting minutes o EPSSLC Plan of Improvement o Log of employees reassigned due to allegations of abuse and neglect since 1/1/11 o Three most recent five-day status reports o Training transcripts 24 employees o Acknowledgement to report abuse for all employees hired in the past two months (3) o Training and background checks for the last three employees hired o Training transcripts for facility investigators o Training transcripts for DFPS investigators assigned to complete investigations at EPSSLC o Abuse/Neglect/Exploitation Trend Reports FY11 o Injury Trend Reports FY11 o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o List of applicants who were terminated based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o Injury reports for three most recent incidents of peer-to-peer aggression incidents o List of all serious injuries for the past six months o List of Injuries by individual since 5/1/10 o List of all A/N/E allegations since 1/1/10 including case disposition o List of OIG cases and the disposition o List of employees reassigned due to ANE allegations o Injury reports and supporting documentation of investigation of injuries for the past three months for Individual #8, Individual #44, Individual #119, and Individual #74. o A sample of Chart Audits for Injuries completed for the following individuals: • Individual #44, Individual #128, Individual #103, Individual 155, Individual #162, Individual #70, Individual #16, Individual #92, Individual #97, Individual #46, Individual #113, Individual ##114, Individual #40, Individual #130, Individual #58, Individual #189, Individual #105, and Individual #191, and Individual #107.

- PSPs for:
  - Individual #161, Individual #67, Individual #69, Individual #164, Individual #191, Individual #13, Individual #10, Individual #182, Individual #107, and Individual #36.

- Documentation from the following completed investigations including follow-up:

Case #	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Initial Contact**	**Date Completed**
Sample D.1					
#11-122 #39898228	Neglect (2)	Unconfirmed (1) Confirmed (1)	6/22/11 12:49 pm	6/23/11 9:40 am	6/28/11
#11-109 #39475907	Physical Abuse	Unconfirmed	5/19/11 4:00 pm	5/20/11 10:20 am	5/25/11
#11-108 #39372827	Neglect Physical Abuse	Unconfirmed Other	5/12/11 12:42 pm	5/12/11 2:54 pm	5/18/11
#11-105 #39222968	Neglect	Unconfirmed	5/1/11 7:30 am	5/3/11* 9:58 am	5/11/11
#11-100 #38985527	Neglect	Confirmed	4/10/11 9:25 pm	4/11/11 4:20 pm	4/20/11
#11-084 #38714411	Physical Abuse	Unconfirmed	3/8/11 7:26 am	3/9/11 9:30 am	3/17/11
#11-093 #38842595	Physical Abuse Neglect	Unconfirmed Other	3/27/11 3:07 am	3/27/11 2:50 am	3/28/11
#11-081 #38699000	Neglect	Unconfirmed	3/3/11 11:53 pm	3/4/11 2:42 pm	3/23/11
#11-099 #38965989	Neglect	Unconfirmed	4/8/11 2:01 am	4/11/11* 9:24 am	4/15/11
Sample D.2	Type of Incident	DFPS Disposition	Time of Incident	Began Investigation	Closed Investigation
#11-126	Neglect	Referred Back Administrative Issue	7/1/11	7/5/11	7/6/11
#11-111	Neglect	Referred Back Client Right Issue	5/27/11	5/27/11	unknown
#11-103	Neglect	Referred Back Clinical Issue	4/22/11	4/22/11	6/7/11
#11-102	Physical	Clinical Issue	4/20/11	4/20/11	5/11/11

	Abuse				
#11-098	Physical Abuse	Referred Back Clinical Issue	4/6/11	4/6/11	5/9/11
Sample D.3					
#11-124	Serious Injury	n/a	6/21/11 10:00 am	6/23/11	6/30/11
#11-095	Serious Injury	n/a	3/31/11 5:15 am	4/1/11 9:50 am	4/14/11*
#11-089	Serious Injury	n/a	3/16/11 9:15 am	3/16/11 9:30 am	3/23/11
#11-088	Serious Injury	n/a	3/17/11 8:10 pm	3/17/11 8:50 pm	3/24/11
#11-06	Sexual Incident	n/a	1/25/11 1:36 pm	1/25/11 1:40 pm	2/8/11*
#11-120	Staff Training Issue	n/a	6/20/11	6/21/11 11:30 am	6/28/11

* = late

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Mario Gutierrez, Incident Management Coordinator
- Michael Reed, Lead Investigator
- Cynthia Martinez, QMRP Coordinator
- Gloria Loya, Human Rights Officer
- Valerie Grigg, Director of Behavioral Services

Observations Conducted:

- Observations at residences and day programs
- Morning Unit Meeting 7/11/11 and 7/14/11
- Incident Management Review Team Meeting 7/12/11 and 7/14/11
- Human Rights Committee Meeting
- Annual PSP meetings for Individual #5 and Individual #43

Facility Self-Assessment:

EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. The facility's POI for section D indicated that the facility had implemented several new processes to address deficiencies noted in the last monitoring report. The facility had begun to audit investigation records for compliance with section D requirements.

	The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility POI indicated that EPSSLC was in substantial compliance with all of the provision items in section D. The facility was in substantial compliance with a majority of the provisions in section D, however, as discussed below, the monitoring did not find evidence to support substantial compliance with provisions D1, D2a, D2e, D2i, D3a, D3e, D3f, or D3g. The POI outlined several steps that had been taken to achieve substantial compliance in a number of areas. This included hiring a new incident management coordinator and plans to train two campus administrators to complete investigations. The creation of an incident management department had already made noticeable changes in the facility's ability to conduct thorough investigations and track follow-up action recommended by the investigator. The facility had implemented a new review sheet for investigations that had improved the facility's ability to ensure completion of recommended follow-up. As noted in the monitoring team's findings, this review was still not occurring in a timely manner. The facility was in the beginning stages of addressing these provisions through the quality improvement process. The facility was now holding daily unit meetings to review all incidents and injuries. Observation of these meetings indicated that this was an effective process for insuring that incidents were reviewed and appropriate recommendations were made regarding incidents. The findings in this section of the report include evidence of positive steps that the facility had taken to meet this provision.
	Summary of Monitor's Assessment: According to a summary of abuse, neglect, and exploitation trends provided to the monitoring team, investigation of 46 allegations cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 1/1/11 through 6/14/11. Of these 46 allegations, 2 (4%) were confirmed allegations by DFPS (including one allegation of abuse and one allegation of neglect), 23 (50%) were unconfirmed allegations, and 18 (39%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect and 3 were other (including pending). There had been a decrease in the number of abuse and neglect allegations from FY11 1st quarter (32) to FY11 2nd quarter (27). The facility investigators conducted investigations for 15 additional serious incidents during the same time period. This included 12 serious injuries and 3 deaths. There were a total of 775 injuries reported since 12/1/10. Of these injuries, 400 were reported in the 3rd quarter of FY11 including 10 serious injuries, 262 non-serious injuries requiring treatment, 111 required no treatment, and 17 were no apparent injury. It should be noted that any time a nurse assessed for an injury, it was counted as an injury in the total number of injuries at the facility, even when there was no injury. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility.

	As noted throughout this report, the facility had implemented a number of procedures to try to address findings by the monitoring team during the last monitoring visit. The monitoring team noted that while in the beginning stages, these new procedures were having a positive impact on efforts to gain substantial compliance with section D requirements. • Since the last monitoring visit, an Incident Management Coordinator had been hired. This freed up the facility's investigator to spend more time completing investigations while the Incident Management Coordinator could ensure that follow-up action for incidents was completed in a timely manner. • Incidents and injuries were being reviewed daily Monday through Friday at a daily unit meeting held at the facility. It was noted in meetings observed, the daily meeting was an effective way to ensure that documentation was completed for each incident and follow-up procedures were tracked and completed. • The two campus administrators had been scheduled to complete investigation training. The facility planned to utilize the campus administrators as backup investigators.

#	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. 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 with both information on identifying abuse and neglect and steps to be taken if abuse or neglect was either suspected or witnessed. • 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 would report the incident to DFPS by calling the 800#. • 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 24 of these 24 employees (100%).	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 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, 24 (100%) had completed the course ABU0100 in the past 12 months. The facility provided the monitoring team with documentation of disciplinary action taken for four confirmed allegations of abuse or neglect. • In DFPS case #38514071, DFPS confirmed an allegation of physical abuse. The AP received a one day suspension before returning to work. • In DFPS case #38463177 and #38502505, allegations of neglect were confirmed against the same AP. The AP was suspended from work for one day. • In DFPS case #38985527, DFPS confirmed an allegation of neglect. The AP was suspended for one day. Disciplinary action did not send a clear message to staff that the facility would not tolerate abuse or neglect of individuals at the facility. The facility was found to be in substantial compliance with this provision during the last monitoring visit. The facility rated itself as being in substantial compliance with this item based on the facility policy in regards to zero tolerance of abuse and neglect. The substantial compliance rating, however, was not confirmed because the facility needs to ensure that disciplinary action taken in regards to confirmed allegations of abuse and/or neglect supports the facility's position on zero tolerance of abuse and neglect.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. 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 immediately, reported to DFPS immediately if abuse or neglect was suspected, to DADS regulatory	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	within 24 hours, and to DADS state office the next working day, if required. It further specified requirements for reporting certain types of incidents to other outside agencies. This policy was consistent with the requirements of the Settlement Agreement. According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 46 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility from 1/1/11 through 6/14/11. From these 46 cases, there were: • 1 confirmed allegations of abuse, • 1 confirmed allegations of neglect, and • 0 confirmed allegation of exploitation. • Confirmed allegations involved 2 different individuals. The facility investigators conducted investigations for 23 additional serious incidents during the same time period. The incidents included: • Serious Injuries – 14 • Non-serious Injuries, Undetermined Cause - 3 • Deaths – 2 • Sexual Incidents – 1 • Suicide Threat– 1 • Other - 2 Based on an interview of eight staff responsible for the provision of supports to individuals, eight (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation and other serious incidents. From the 46 investigations since 1/1/11 reported by the facility, 20 (43%) investigations were selected for review. This included three samples of investigations: • 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 that had been referred to the facility by DFPS for further investigation. • Sample #D.3 included investigations the facility completed related to serious incidents. Based on a review of the nine investigative reports included in Sample #D.1: • Seven of nine (78 %) reports in the sample indicated that DFPS was notified within one hour. o This was not the case for the following DFPS investigations: UIR #11-	

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		099 and UIR #11-093. Both were reported by an unknown witness of the supposed incident. Allegations were unconfirmed in both cases • Nine (100%) indicated, the facility director or designee was notified within one hour. • Four of four (100%) indicated OIG or local law enforcement (when appropriate) was notified within the timeframes required by the facility policy. • Nine (100%) investigation reports in the sample indicated that the state office was notified of the incident. In reviewing Sample D.3 (serious injuries) one of four (25%) were reported immediately (within one hour) to the Facility Director/designee. The sample included UIRs for Individual #13 dated 6/22/11, Individual #8 dated 3/17/11 and 3/31/11, and Individual #73 dated 3/16/11. The facility director was not notified within one hour in the following incidents:: • Individual #13 was seen in the clinic for a laceration on his head on 6/22/11. The FNP determined that the injury was serious at 9:50 am. According to the UIR, the director was not notified until 2:30 pm at the Incident Management Review Team Meeting. • Individual #8 sustained a serious injury to his head at 5:15 am on 3/31/11. The director was not notified of the injury until 11:15 am at the Incident Review Team Meeting. • Individual #8 sustained a serious injury to his foot on 3/17/11. The UIR did not indicate what time the director was notified of the incident The facility had a standardized reporting format. The facility used the Unusual Incident Report Form designated by DADS for reporting unusual incidents other than serious injuries. Serious injuries were documented on the EPSSLC Client Injury Report. This form was adequate for recording information on the incident, follow-up, and review. Based on a review of 11 incident reports included in Sample #D.2 and Sample #D.3: • Eleven (100%) utilized the standardized reporting format. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was requested for new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees in the sample had signed this form. The facility POI indicated that it was in compliance with D2a. No new action had been taken to address this provision. The facility needs to ensure that all serious incidents are	

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		reported to the facility director and outside entities as required. The monitoring team did not find that the facility was in compliance with this requirement.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	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. 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 facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of nine investigation reports included in Sample D.1 in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status. Additionally, the monitoring team was provided with a log of employees who had been reassigned since 1/6/11. The log included the applicable UIR number, the date of the incident and the date the employee was returned to work if the employee was not discharged or had resigned. Review of nine investigation files included in Sample D.1 showed there were no instances where staff who had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment posed a risk to individuals or the integrity of the investigation. Based on a review of the nine investigation files in Sample D.1, it was documented that adequate additional action was taken to protect individuals in each case. For example, nursing assessments were done and treatment rendered as appropriate, emotional assessments of were conducted by psychology staff, and repairs to physical property were completed when necessary. The facility is in substantial compliance with this provision item.	Substantial compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Documentation of training was kept by the facility and a sample of 24 staff training transcripts was reviewed. 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: Review of 24 staff records (Sample #C.2), showed that; • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 22 (92%) employees with current training completed this training within 12 months of the date of previous training if not hired in the past year. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • Two (8%) of the 24 employees with current training completed this training within 12 months of the date of previous training. Based on interviews with ten staff: • Ten (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility training department sends out training reminders to supervisors for employees who have training due and reminders when training is delinquent. The facility was in substantial compliance with this 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 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.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A sample of this form was requested for 24 current employees at the facility. All (100%) employees had signed this form within the past 12 months. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility was asked for a list of staff identified as having failed to report abuse and/or neglect. This generated a list of zero staff. There was no indication in the sample reviewed that staff had failed to report abuse and neglect immediately as required by policy. The facility was in substantial compliance with this item.	Substantial Compliance

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	(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.	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. In interviewing a sample of six individuals, all six (100%) said that they would call the DFPS hotline or tell a staff person if someone hurt them or they saw someone being hurt. Two of the individuals were able to point out the poster with the #800 on it at the home. Based on a review of 10 individuals' PSPs, zero (0%) indicated the individual, or his or her LAR and/or other significantly involved individual, had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. Documentation was not provided to the monitoring team to verify that families were provided with this information. This sample included PSPs for the Individual #161, Individual #67, Individual #69, Individual #164, Individual #191, Individual #13, Individual #10, Individual #182, Individual #107, and Individual #36. The facility POI indicated that all QMRPs and the QMRP Coordinator were in-serviced to document in their annual PSP that they reviewed the brochure(s) regarding A/N/E with the LAR, guardian or individual. It further indicated that the IMC had reviewed several PSPs and verified that this was being done. The monitoring team did not find documentation in PSPs. QMRPs will need to be reminded to include this information in the new PSP plan development process. Documentation that information on identifying and reporting unusual incidents was shared with the individual and/or their LAR will need to be maintained by the facility.	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.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • 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 all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access.	Substantial Compliance

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		An assistant independent ombudsman position had been created at the facility. There was also a rights officer position. Information was posted around campus identifying the rights officer and ombudsman. The rights officer was well known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. The facility's POI indicated compliance with this item and noted that the campus administrators are monitoring all units to ensure the posters remain in place. 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.	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. Based on a review of nine allegation investigations completed by DFPS (Sample #D.1), in four for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in four (100%). OIG did not find evidence of criminal activity in any of the cases in the sample. 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.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	According to EPSSLC Protection From Harm – Abuse, Neglect, and Exploitation Policy, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. 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. Based on a review of investigation records (Sample #D.1), there were no concerns noted related to potential retaliation. The facility reported that there had been no staff who had alleged that they were retaliated against for in good faith reporting an allegation since the last monitoring visit. The facility rated itself in substantial compliance with this item. The monitoring team agrees with that assessment. The facility was in substantial compliance with this item.	Substantial compliance

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	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Sample #D.3 included investigations completed on a sample of serious injuries. The facility investigator completed investigations on all serious injuries. Home staff were responsible for completing an initial investigation form for non-serious injuries, including those of unknown cause. A sample of injury reports and supporting documentation was reviewed for the past three months for Individual #8, Individual #119, and Individual #74. Uniform Client Injury Reports were completed routinely on all injuries. For example: • Three injury reports were completed for Individual #8 on 3/3/11 and 3/2/11 regarding multiple bruises and lacerations to his arms, back, and face. The injuries were significant enough that three separate staff completed Client Injury Reports. One staff noted that the bruises on his arm "looked like finger marks". These injuries were not reported for investigation. • Individual #119 had an injury report dated 3/9/11 after staff discovered her mouth bleeding with bruising and swelling of her face. She was sent to the emergency room for x-rays. Although the injury was not witnessed, an investigation was not completed to try to determine the cause of the injury. A sample of Daily Incident Management Meeting (DIMM) minutes since the last monitoring review were reviewed and indicated that injuries of both known and unknown cause were routinely reviewed by the committees. Observation of both the Daily Unit Meeting and Daily Incident Management Meeting during the monitoring visit confirmed that injuries were reviewed by both teams and follow-up recommendations were made when warranted. This provision item, however, requires an audit process. To that end, according to the facility POI, the facility had developed an audit tool to monitor compliance with this provision. The facility had just begun to implement monitoring as of 6/1/11. A sample of completed chart audit forms was reviewed by the monitoring team. The completed forms included a list of documented injuries, whether the injury was witnessed or discovered, and the severity of the injury. There were columns to indicate if an investigation was completed and any follow-up completed as a result of IMRT review. These two columns were not completed for any of the injuries documented. It was not clear how these forms were being used to ensure investigations of injuries are completed when appropriate. For example, the chart audit for Individual #155 listed 10 injuries that were noted in observations notes. One of those injuries was a bruise and swelling on her chin that was discovered by staff. The audit tool indicated that an injury report was completed, but did not note whether or not the injury was investigated to determine a cause of the injury or rule out possible abuse or neglect.	Noncompliance

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		The POI rated this section as being in substantial compliance. The monitoring team will review this newly developed process further during the next review. The facility was not yet in compliance with this provision.	
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 Incident Management Policy • described a comprehensive manner of the conduct of all such investigations; • addressed training requirements for investigators including training in working with people with developmental disabilities; and DFPS reported its investigators are to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on working with people with developmental disabilities. Three DFPS investigators were assigned to complete investigations at EPSSLC. The training records for DFPS investigators were reviewed with the following results: • Three investigators (100%) had completed the requirements for investigations training. • Three DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. EPSSLC had two designated facility investigators. The two campus administrators were in the process of completing required training so that they could also complete investigations at the facility. At the time of the monitoring visit, they had not yet completed any investigations. The training records for facility investigators were reviewed with the following results: • Two (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training;	Noncompliance

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		• Two (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Two (100%) had completed Root Cause Analysis according to training transcripts reviewed; and • Two (100%) had completed the requirements for training regarding individuals with developmental disabilities. Investigations of injuries were not routinely completed by trained investigators at the facility. Staff designated to complete initial injury investigations had supervisory responsibilities and, therefore, were in the direct line of supervision of staff subject to investigation. The facility investigators did investigate serious injuries, but, in some cases, supervisory staff had already taken witness statements. It is recommended that injury investigations be completed by the Incident Management Department in order to prevent the contamination of evidence if further investigation is warranted, particularly in the case of discovered injuries. The facility POI rated this item in substantial compliance based on the campus administrators receiving training to complete facility investigations. At the time of the review, they had not yet completed this training. It is expected that once they complete training, the Incident Management Department will have the capacity to complete investigations on injuries when warranted. The facility remained out of compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Review of the investigation files in Sample #D.1 showed that in nine out of nine 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. OIG was routinely informed of investigations. The Incident Management Coordinator reported that the facility had a cooperative relationship with both DFPS and OIG. The facility self assessment rated this item as being in substantial compliance. The monitoring team found that the facility is in substantial compliance with this item.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not	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	Substantial Compliance

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	to interfere with such investigations.	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, the following was found: • Of the nine investigations completed by DFPS (Sample #D.1), four had been referred to law enforcement agencies. For four out of these four (100%), it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • OIG did not find criminal evidence of criminal activity in any of the cases in the sample. • There was no indication that the facility had interfered with any of the investigations by OIG. According to a log provided to the monitoring team, OIG had investigated 18 cases at the facility since 1/1/11. They did not substantiate criminal activity in any of the investigations. The facility was found to be in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	The EPSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video monitoring footage was provided to DFPS as requested and reviewed by facility investigators and photographs were taken of injuries as necessary. The facility was in substantial compliance with this item.	Substantial compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being	The facility Incident Management policy mandated investigations of serious incidents: • were to commence begin immediately for all unusual incidents; • were to be completed within five working days of the incident; • did require a written extension request from the facility director or Adult	Noncompliance

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	reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Protective Services Supervisor to be completed outside of the 10-day period; and • were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Nine out of nine (100%) commenced within 24 hours or sooner. 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. In addition, DFPS was in the process of modifying standard operating procedures regarding the conduct and documentation of actions taken to commence an investigation. • Eight of nine (89%) were completed within 10 calendar days of the incident. o The investigation for UIR #11-081 was completed in 20 days. DFPS filed an extension on the 10th day citing that witnesses had not been available for interview. • All nine (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In five (17%) of the 30 investigations reviewed, concerns or recommendations for corrective action were included. In UIR #11-105, UIR #11-108, and UIR #11-122, the investigator noted concerns regarding staff activity involved in the video footage reviewed in each of those cases. Concerns were referred back to the facility to address. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2 and #D.3 : • Ten out of 11 (91%) of the UIRs reviewed indicated that the investigation commenced within 24 hours of the incident. The exception was UIR #11-126. The incident occurred on 7/1/11. The investigation did not commence until 7/5/11.	

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		• Five of 11 (45%) indicated that the investigator completed in report within 10 days of notification of the incident or following referral back to the facility by DFPS. o UIR #11-064 both indicated that the report was completed 14 days from the initial incident. o UIR #11-095 indicated that the report was completed 13 days from the initial incident o For UIR #11- 098 DFPS completed its report in seven days and referred the case back to the facility. The facility completed its investigation 12 days after it was referred back. o For UIR #11-102, DFPS completed its report in one day and referred the case back to the facility as a clinical issue. The facility completed its investigation 21 day after it was referred back. o For UIR #11-103, DFPS completed the investigation in seven days and referred the case back to the facility as a clinical issue. It did not appear that the facility completed any additional investigation. The facility investigator did not sign the UIR for completion until 6/7/11. An extension was included in the investigation file but was not dated. o For UIR #11-111, DFPS completed the investigation in seven days and referred the case back to the facility as a rights issue. The facility UIR did not indicate when the investigation was closed by the facility. • Ten (91%) of the investigations completed in the sample indicated that the facility director and incident management coordinator had reviewed the report upon completion. UIR #11-103 was not signed by the Incident Management Coordinator or Director. Four of the 10 (40%) reports reviewed of did not indicate that this review was completed in a timely manner. The exceptions were UIR #11-089 (reviewed 71 days after the close of the investigation), UIR #11-095 (reviewed 28 days after the incident), UIR#11-102 (reviewed 21 days after the close of the investigation), and UIR #11-111 (reviewed 28 days after the close of the DFPS investigation). • All 11 (100%) investigations 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 in section D3f. • In 11 investigations reviewed, recommendations for corrective action were included in 10 of the investigations (91%). The facility had developed a Request for Extension of Facility Investigation form to be used for events where an investigation cannot be completed in 10 days. The extension form provided information on the case for which an extension was being requested, and	

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		the reason for request. The request was to be reviewed and approved by the IMC and the facility director. The most recent cases reviewed included this form when the investigation was not completed within required time frame. Based on the percentage of facility investigations in the sample that were not completed within required timeframes, the facility was rated as not in compliance with this provision. It is expected that once the campus administrators have completed training and can begin assisting with investigations, the facility will be able to do so.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the	EPSSLC Incident Management Policy required a UIR to be completed for each serious incident. 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: • Seven of nine investigation reports in sample #D.1 were sufficient to provide a clear basis for its conclusion. Exceptions included: o UIR 11-105 was an allegation of neglect reported to DFPS. The investigator concluded that, "The preponderance of evidence proves that the AP did not neglect the individual, therefore the allegation of neglect was unconfirmed." The investigator then cited the following concerns regarding evidence viewed on video surveillance tape: ▪ AP did not assist the individual into the chair using his gait belt, which resulted in him falling to the floor. ▪ AP was assigned one to one 24/7 supervision of the individual. His general risks included hitting walls and windows with his hand, attempting to steal food, re-opening wounds, and removing his G-tube. The AP sat at a table with her back facing the individual from 6:17 am to 6:30 am while she applied her make-up. The investigator only viewed the videotape of the day of the incident through 6:30 am. She noted that it was unknown how much longer she continued to sit there and apply her make-up. o UIR 11-108 was an allegation of neglect resulting from a restraint for Individual #81. The facility reported the incident to DFPS after viewing a restraint that did not follow PMAB procedures on video surveillance.	Noncompliance

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	investigator's reasons for his/her conclusions.	The DFPS investigator concluded the allegation was unconfirmed. He concluded that, "it was a concern that the initiation of the PMAB technique was not conducted as instructed, however, during the process no harm came to the consumer." The definition of neglect includes acts that place the person served at risk. While his conclusion acknowledged that PMAB techniques are utilized to protect individuals from harm, he did not find it neglectful that those procedures were not followed. • For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In nine (100%), each serious incident or allegations of wrongdoing; o In nine (100%), the name(s) of all witnesses; o In nine (100%), the name(s) of all alleged victims and perpetrators (when known); o In nine (100%), the names of all persons interviewed during the investigation; o In nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In nine (100%), all documents reviewed during the investigation; o In two (22%), 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 two most recent investigations included a statement indicating that previous investigations were reviewed and found not relevant to the case. o In nine (100%), the investigator's findings; and o In nine (100%), the investigator's reasons for his/her conclusions. DFPS was preparing to implement policy and procedure that will instruct investigators to document the results of the prior case history review in the investigative report whether it was used or not. Previously, this information was stored in the IMPACT case management system, but did not translate to the written report. DFPS reported that it was making arrangements to modify the IMPACT case management system to include information about prior case history in the printed report that is mailed to the facility. This change was scheduled to occur May 2011. <u>Facility Investigations</u> The following summarizes the results of the review of five facility investigations included in sample #D.2 • The report utilized a standardized format that set forth explicitly and separately, the following:	

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		o In five (100%), each serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; o In five (100%), the name(s) of all alleged victims and perpetrators when known; o In five (100%), the names of all persons interviewed during the investigation; o In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In nine (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. Facility investigations did not include historical information on previous incidents that might be relevant to the investigation. o In five (100%), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. Facility investigations were consistently formatted and well organized. As noted in the examples above, not all DFPS investigations included clear evidence to support the investigator's findings in the case. When evidence does not support the findings in DFPS investigations, the facility should request further review. The facility will also need to include relevant previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) in the sources of evidence reviewed for each investigation. The facility was not in substantial compliance with this item.	
	(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.	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 a sample of 9 DFPS investigations included in Sample #D.1: • In 9 investigative files reviewed (100%), there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. • UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC), Director of Facility, and reviewed by the Incident Management Committee. Thirty (100%) DFPS investigations were	Noncompliance

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		reviewed by the facility director, and IMC following completion. o Zero (0%) were reviewed by the Facility Director and Incident Management Coordinator within five days of completion. The following cases were not reviewed within 5 days by either the IMC or Facility Director: UIR #11-99 (no review date documented), #11-81 (60+ days), #11-093 (6 days), #11-084 (11 days), #11-100 (23 days), #11-105 (28 days) #11-108 (48 days), #11-109 (13 days), and #11-122 (was reviewed at the time of the monitoring visit). • DFPS noted concerns or made recommendations in three (33%) of the cases in sample #D.1. The facility documented follow-up to recommendations made by DFPS in all three cases. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In 10 out of 11 (91%) UIRs from sample #D.2 and #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. As noted in D.3.e, this review was not timely in all cases. Recommendations for follow-up were made in 10 of the 11 investigations completed by the facility. Although the facility had implemented a new form for review of investigations as noted in the facility POI, the reviews were not completed in a timely manner. While the facility rated itself in substantial compliance with this provision, the monitoring team did not find the facility to be meeting this requirement. The facility needs to ensure that completed DFPS investigations are reviewed by the IMC and facility director in a timely manner.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A UIR was completed for each unusual incident in the sample.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall	In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1, Sample #D.2, and #D.3 was selected for review. This subsample included the following investigations: UIR #11-124, UIR #11-111, UIR#11-109, UIR #11-108, UIR #11-105, and UIR#11-100.	Substantial Compliance

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	implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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: • Only one incident in the sample included a confirmed allegation by DFPS. UIR #11-100 was a confirmed allegation of neglect. There was evidence that disciplinary action was taken in this case. All investigations in the sample included retraining of staff when warranted. For example, the following actions had been taken and documented in regards to follow-up in the cases in this sample: o For UIR #11-100, the facility received the final DFPS report on 4/22/11. Disciplinary action was reviewed with the AP on 5/5/11. The AP remained on "no contact with client" status until retraining was completed. o For UIR #11-111, DFPS referred the investigation back to the facility as a rights issue. Both APs were retrained in regards to consumer rights and one AP received a first level warning. o For UIR #11-111, Individual #13 received a serious injury when he hit his head on the headboard of the bed. The investigator recommended that the headboard be repaired since exposed screws and sharp corners made the headboard a safety issue. The IMC followed up with the maintenance department to have work completed. o DFPS investigated an allegation of neglect in UIR #11-105. The allegation was not confirmed though the investigator raised concerns regarding staff performance. The facility followed up by retraining staff and implementing disciplinary action prior to the AP returning to her previous position. o For UIR #11-108, DFPS expressed concern regarding the incorrect implementation of a restraint in the incident. The AP was retrained on PMAB and consumer rights. The facility had begun to use a new format to track follow-up on recommendation in June 2011. The newly appointed IMC was responsible for ensuring follow-up was completed. The facility POI indicated that the facility was in substantial compliance with this provision. Based on the sample reviewed, the monitoring team found that the facility followed up on all recommendations from investigations and documented follow-up in the investigation file.	
	(j) Require that records of the results of every investigation shall be maintained in a manner	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 request.	Substantial Compliance

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	that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	All facility investigations in the review included information about past allegations for both the individual involved and the alleged perpetrators. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The team agreed with this facility's self assessment rating of substantial compliance with this item.	
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 on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • Type of incident, • Staff involved in 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. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress. The facility assigned a substantial compliance rating to D4. The facility was in substantial compliance with this provision item.	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	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	Substantial Compliance

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	investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	• 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. 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 employees confirmed that their background checks were completed. The information obtained about volunteers was also reviewed. According to information provided to the monitoring team, • No employees had been terminated since the last monitoring visit based on background checks. • For FY11, criminal background checks were submitted for 526 applicants 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 fingerprint checks annually. 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 was requested for 24 employee's acknowledgement to self report criminal activity forms. The facility provided examples of where employees had submitted a form reporting criminal activity. The facility's POI indicated substantial compliance with this D.5. The monitoring team agreed with this rating.	

Recommendations:

1. The facility needs to ensure that disciplinary action taken in regards to confirmed allegations of abuse and /or neglect supports that facility's position on zero tolerance of abuse and neglect. (D1)

2. The facility needs to ensure that all serious incidents are reported to the facility director and outside entities as required. (D2a)

3. The facility needs to ensure notification is made to all parties required within required timeframes in regards to investigations and documented in the UIR. (D2a)

4. When evidence does not support the findings in DFPS investigations, the facility should request further review. (D3f)

5. Ensure DFPS 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. (D3f)

6. Include evidence in PSPs that information on identifying and reporting abuse and neglect is shared with individuals and their LARs. (D2e)

7. The facility needs to ensure that all significant injuries are investigated and reviewed by the facility. (D2i, D3e)

8. The facility needs to ensure that completed DFPS investigations are reviewed by the IMC and Facility Director in a timely manner and concerns raised during investigations are adequately documented and promptly addressed. (D3e, D3f, D3g)

9. The facility needs to ensure that follow-up action is taken and documented when appropriate. A system will need to be developed to track outstanding recommendations and ensure documentation of follow-up action is included in the investigation file. (D3g)

10. Examine facility trends and look at specific indicators to develop a plan of correction to address any trends identified in injuries and incidents. (D3g)

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:** <u>Documents Reviewed</u>: o DADS policy #003: Quality Enhancement, dated 11/13/09 o DADS Draft revised policy on Quality Enhancement, undated o Organizational chart, undated, but current o EPSSLC policy lists, 4/8/11 o List of typical meetings that occurred at EPSSLC o EPSSLC POI, 7/1/11 o EPSSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/11/11 o EPSSLC DADS regulatory review reports, 6/15/11 o EPSSLC Quality Assurance Plan (three page table/matrix) o QA department staff meeting note 6/17/11 o Set of blank tools used by QA department staff o List of reports generated by EPSSLC QA department • Data/spreadsheets from some of these reports o EPSSLC trend analysis (four topic areas) o Data system for self-monitoring tools • Overview spreadsheet • Monthly bar graphs per lettered provision (for most, but not all) • Spreadsheets of department scoring (some examples) • Spreadsheets of inter-rater scores between department and QA staff • Training and description materials regarding entering and management of self-monitoring o QAQI Council calendar, March 2011 through September 2011 o QAQI Council agenda and meeting minutes from January 2011 through July 2011 (13 meetings) o PIT meeting minutes, February 2011 through April 2011 (three meetings) o DADS EPSSLC family satisfaction survey online summary, 27 respondents o Self-advocacy meeting minutes and notes, January 2011 through May 2011 (five meetings) <u>Interviews and Meetings Held</u>: o Mary Stohr, Director of Quality Assurance o Elaine Lichter, RN, Petra Robledo, Victor Quiroz, Erna Matthews, EPSSLC QA department staff o Jaime Monardes, Facility Director o Helen Alvarez, Settlement Agreement Coordinator; Bertha Macias-Muro, Settlement Agreement Clerk o Unit Director: Jeff Moody

	Observations Conducted: o QAQI Council Meeting, 7/13/11 o Many residences, day program, and vocational program
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. In addition, during the onsite review, the QA director reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the QA director wrote a sentence or two about what tasks were completed and/or the status of each provision item. For instance, 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 POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The QA director self-rated the facility as being in noncompliance with all five provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, all taken from this monitoring report, are set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: EPSSLC had made some, but not a great deal of, continued progress towards achieving substantial compliance. Improvement will be necessary in the key areas of this provision: QA policy, QA plan, QA data collection and analysis, QAQI Council, and the management of corrective actions. Progress was evident in two areas in particular. First, implementation and management of self-assessment monitoring tools for each of the Settlement Agreement provisions for which a tool existed (i.e., most, but not all) was regularly occurring. Second, the QAQI Council met regularly and had good attendance and participation. The group was discussing important topics, including the formation of work groups to attend

	to identified problems. QA policy and a QA plan were not yet developed. A QA report and a system of managing corrective actions were also not yet in place. Without these components, the facility was unable to thoroughly review, analyze, and summarize important data. The data analyst managed a number of databases, some of which were used by QAQI Council to create workgroups and to make decisions, such as guardianship status and weight. These databases will need to be incorporated into the overall QA program, including the QA plan and QA report. QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, and conducted a variety of audits. Primarily, their time over the past few months was spent conducting reliability interobserver agreement reviews of each department's scoring of the self-assessment tools. Below, numerous suggestions are provided to the QA director and the facility regarding all aspects of the QA program.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	EPSSLC had made some, but not a great deal of, continued progress towards achieving substantial compliance. Improvement will be necessary in the key areas of this provision: QA policy, QA plan, QA data collection and analysis, QAQI Council, and the management of corrective actions. <u>Policies and QA Planning</u> The DADS statewide policy #003: Quality Enhancement, dated 11/13/09, was adopted by the facility. This state policy, however, was being extensively revised and was likely to be disseminated some time in the next few months. The facility will likely benefit from receiving additional direction via this new policy. EPSSLC did not have any facility-specific QA policies. Once the state policy is disseminated, the QA director should strongly consider whether facility-specific policies would be helpful to the QA program at the facility. Below are comments from the monitoring team regarding EPSSLC's status with some important component steps in the development of a QA program: 1. Create a listing of all data collected at the facility that includes the following: a. Data collected by each discipline service department; this includes two categories of data: i. Data the discipline service department uses for its own service	Noncompliance

#	Provision	Assessment of Status	Compliance
		and operational purposes ii. Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools: • Statewide self-monitoring tools • Facility-specific tools created by the facility service department, if any (e.g., PNMP monitoring, AAC device monitoring) b. Data collected by the QA department staff: i. Data they collect themselves ii. Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring c. Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, and the FSPI. Status: EPSSLC had not yet begun to assemble this listing. 2. Determine which of these data are to be submitted to the QA department for tracking and trending. Status: The QA department had made some progress on this activity by beginning to develop a detailed table/matrix of measures and tools, however, it was not based upon working from a long listing of all available data because, as noted immediately above, this task had not yet been completed. The table/matrix should be further developed to include all data that the QA department will track, trend, and comment upon. Further, the table/matrix will become part (the primary part) of the QA plan. 3. Determine which of these data are to be included in the QA report. Status: The QA director had not yet created a QA report. 4. Determine which of these data are to be presented regularly to the QAQI Council. QAQI Council should make this determination with suggestions from the service department heads as well as from the QA director. Status: The QAQI Council was reviewing some data, discussing those data, and making recommendations (see below), but again, they were doing so without the benefit of a listing of all types of facility data, the QA table/matrix, or any other guidance from the department heads or QA department. 5. Create and manage corrective actions based upon the data collected and direction from the QAQI Council. Status: The QAQI Council created some action plans and some work	

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		groups based on the information and data that was brought to the committee (see below). A system of managing corrective actions (of which the formation of a PIT might be one) was not yet in place. <u>QA Department</u> Mary Stohr remained as QA director. Recently, her risk management responsibilities were assigned to another manager. She expected that she would now be able to devote more efforts to all of the items of this provision. The QA director reported that she was in regular contact with the QA director at another SSLC. The monitoring team recommends that this continue to occur. The monitoring team again met with the QA director and her staff. The staff consisted of two program auditors, a QA nurse, and a QA data analyst. The staff were hard working and truly wanted to conduct QA activities that would be beneficial to the services provided to the individuals at EPSSLC as well as their staff, clinicians, and managers. It appeared that the QA department had recently (June 2011) begun to hold QA department staff meetings. These should continue to occur regularly. <u>Quality Assurance Plan</u> EPSSLC did not have an adequate or thorough QA plan in place. The QA director had taken a first step towards the creation of a QA plan by beginning to develop a table/matrix of types of data that would be submitted to the QA department. This table/matrix is discussed above. Ultimately, the table/matrix should be a component of the QA plan (albeit probably the largest component). The table/matrix should indicate which data will be managed by the QA department. This means that all of these data on the table/matrix will be reviewed, analyzed, perhaps graphed and trended, and commented upon, if necessary. The table/matrix will also likely include more detail about how each of these types of data will be obtained (e.g., by whom, how often, what tool, sample size). The new state policy will provide guidance to the facility regarding the content of a QA plan. A QA plan will be a description of the overall QA program at the facility. Therefore, to reiterate, the table/matrix that was created will be a piece of this broader QA plan. In addition, it will include all of the data and activities conducted by the QA department as well as the facility's service and operational department self-monitoring data and other relevant data.	

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		QA Activities and Indicators The activities of the QA staff were primarily: • Completion of service department self-monitoring tools for the purpose of assessing interobserver agreement (see more detail below) • Collection of data/audits • Participation on various committees and attendance at various meetings • A set of databases, maintained by the data analyst. The QA department created a good system for the management of the set of self-monitoring tools for each of the Settlement Agreement provisions. The effort at EPSSLC was led by the data analyst and was one of the primary improvements in the QA program since the last onsite review. He was competent and organized. His work put the infrastructure in place so that service departments could enter their data into the computer database, and QA staff could enter the data from their own interobserver reliability checks. There was a training and demonstration system as well. The system has these components: • A single page coversheet showing 12 months of information regarding whether at least one department and one reliability check were conducted each month. • A bar graph, one page per provision, showing the overall self-assessment score for that provision per month (a line graph would be better). • Item by item scoring by the department for each item on each self-assessment. • Item by item interobserver agreement between the department and QA staffs The QA staff reported that a great deal of meaningful discussion about definitions and criteria for scoring had occurred between the department staff and the QA staff when they compared their scores. The next steps are to (a) ensure that the content of the self-assessment tools are correct and valid, and (b) use the data to make changes, provide praise, and so forth. Further, the data analyst should have two graphs per provision per month: one that shows the month to month overall score (this was already being done), and one that shows the detail for that month's score (this was not yet being done). In previous monitoring reports, the monitoring team recommended that a variety of satisfaction measures be obtained, summarized, and included as part of the QA system at EPSSLC. One suggested target was staff satisfaction. The facility had not addressed this yet. Another suggested target was family satisfaction. EPSSLC families and LARs had the opportunity to participate in the new statewide online (or paper) questionnaire. Since the last onsite review, 27 families had completed the survey. The facility did not yet appear to be doing anything with this information. A third suggested target area was	

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		satisfaction of individuals. This was not being done in any type of standardized or formal manner. The HRO, however, addressed the recommendations from the previous report regarding including a decision making component to the self-advocacy meetings. A fourth suggested target was others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. This had not been addressed yet.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. EPSSLC had not made much progress in this area. <u>QA Data Management and Analysis</u> As the facility moves forward, it will be important for the QA director to review all data that are managed by the QA department (i.e., all of the data on the table/matrix). These data will need to be summarized and trended, such as on a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. Not all of these graphs need to be created by the QA department. It is possible that the facility sets an expectation for the service departments to submit their data and their graphic summaries each month. This will have to be determined at the facility level. Many, if not all, of these graphic presentations should/can appear in the QA report and be presented to QAQI Council. The data analyst maintained a set of databases. A three-page list was given to the monitoring team along with some sample reports (guardianship status, weights, medication errors), however, it was not clear if a regular report was generated for every item, and if there was some sort of data review or analysis process for any reports that might have been generated. Overall, to meet the requirements of this provision item, a system and an expectation needs to be created to (a) analyze data regularly, and (b) act upon the findings of the analysis. The statewide trend analysis document deserves special mention. For the past few years, every SSLC created an almost identical monthly report on four sets of data: restraint usage, abuse and neglect allegations, injuries, and unusual incidents. These are important topics and the report provided a lot of valuable information. Each facility now had data for three or so years. The document, however, was cumbersome and lengthy. The QA director will need to take the most important parts of this trend analysis	Noncompliance

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		document and incorporate them into the facility's QA program (e.g., table/grid, QA report, report to QAQI Council). <u>QA Report</u> A QA report did not yet exist at EPSSLC. It is likely the new state policy will provide guidance to the QA director as she develops a report format. The monitoring team recommends that each report include the current month's self-monitoring detail (i.e., results on each of the provision items) as well as a second graph showing month to month overall self-monitoring results (i.e., a single data point for the month). Other data, as per the QA table/matrix, the QAQI Council's preferences, and any other data deemed noteworthy by the QA director or department heads should be included. <u>QAQI Council</u> The QAQI Council met regularly (more than once each month) and was another improvement since the last onsite review. The QAQI Council appeared to take their responsibility seriously as evidenced by the frequency of meetings, their length, and the attendance and participation of senior management. The facility had a plan, though not yet implemented, to have a standard agenda of regular topics (e.g., status of regulatory deficiencies) and a rotating agenda of a set of Settlement Agreement provisions. The rationale was to allow for a more meaningful discussion of a smaller set of provisions and their related data. This appeared to the monitoring team to be a reasonable way to proceed. The monitoring team reviewed meeting minutes and observed conduct of a QAQI Council meeting. It appeared that the group discussed a number of important topics, reviewed some data, and set in motion actions to be taken regarding, for example, weights, allegations, documentation/data, guardianship, and activity engagement. The facility should consider designating these committees as Performance Improvement Teams to be consistent with other facilities, with what the new policy is likely to call for, and to highlight the importance (and perhaps time limited nature) of their work. <u>Performance Improvement Teams</u> As noted immediately above, Performance Improvement Teams were not used at EPSSLC, though they should be created regularly as needed. Further, the monitoring team recommends that the QAQI Council have input into the activities of each PIT rather than solely appointing the PIT. The facility had a list of what it called Standing Committees. Some of these might be more appropriately considered PITs. (The facility previously had a committee called the	

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		Performance Improvement Team. It was disbanded recently and its activities rolled into the QAQI Council.) <u>Corrective Actions</u> The facility had not yet implemented an overall plan to address the management of all corrective actions as required by provision items E2, E3, E4, and E5 was not being done as required. This was also acknowledged in the facility's POI. The QA director submitted some documentation regarding the committee work done to address weight and documentation/data. A more organized system to manage corrective actions is needed. The monitoring team has a number of considerations for the facility as it moves forward with meeting the requirements provision items E2-E5. These considerations could be included in EPSSLC's facility-specific policies regarding QA and the QAQI Council. • How to determine whether or not corrective action is required (e.g., based on scoring of a monitoring tool, based on a level of data submitted, based on discussion at QAQI Council). • If there is a determination that corrective action is required, describe what that action will be. A formal Corrective Action Plan (CAP) is one possibility, but there are other types of corrective actions that might be more appropriate (e.g., development of a new policy, decision by facility director). • Create a method for tracking all corrective actions, not only corrective actions that require a CAP. • A corrective action, whether it be a CAP or not, may involve the formation of a Performance Improvement Team (PIT). A PIT, once formed, might also delegate certain activities to a Performance Evaluation Team (PET). • Specify how the facility's practices for implementing corrective actions will meet the requirements of the items of this provision, that is: o E2: identify the actions that need to be taken to remedy and/or prevent the recurrence of problems, the anticipated outcome of each action step, the person(s) responsible, and the time frame in which each action step must occur o E3: disseminate corrective action plans o E4: monitor and document implementation and outcomes of the corrective action o E5: modify corrective actions when needed.	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	EPSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	EPSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	EPSSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Implement new state policy (E1).

2. Consider whether facility-specific policies would be helpful to the QA program at the facility (E1).

3. Implement the five component steps numbered and described in E1
    - Create a listing of all data collected at the facility
    - Determine which of these data are to be submitted to the QA department for tracking and trending
    - Determine which of these data are to be included in the QA report.
    - Determine which of these data are to be presented regularly to the QAQI Council.
        - QAQI Council should make this determination with suggestions from the department heads as well as from the QA director.
    - Create and manage corrective actions based upon the data, and direction from QAQI Council (also see #14 below, regarding items E2-E5)

4. The QA director should maintain regular contact with the QA director at another SSLC for collaboration, guidance, sharing of best practices, etc. (E1).

5. Hold regularly occurring QA department staff meetings (E1).

6. Develop a QA plan (E1).

7. Ensure that the content of the self-assessment tools are correct and valid (E1).

8. Create two graphs per provision per month for the self-assessment date: one that shows the month to month overall score (this was already being done), and one that shows the detail for that month's score (E1).

9. Conduct, analyze, and then use satisfaction measure results (E1).
10. Review, graph/trend, analyze, and summarize all data managed by the QA department (i.e., the data from the table/matrix) (E2).
11. Create a QA report (E2).
12. The QAQI Council should regularly review data (E2).
13. Create performance improvement teams as needed; QAQI Council should have input into its activities (E2).
14. Ensure data review activities that were conducted by the former PIT are incorporated into the QA program.
15. Implement and manage corrective actions as per items E2-E5 (E2-E5).

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 Supporting Visions Training Curriculum o EPSSLC List of PSP development dates and admission dates o EPSSLC Plan of Improvement o PSP, PSP Addendums, Assessments, SAPs for the following Individuals: • Individual #161, Individual #13, Individual #16, Individual #164, Individual #61, Individual #183, Individual #10, Individual #107, Individual #67, Individual #69, Individual #191, Individual #36, Individual #184, Individual #80 o PSPs and BSPs for the following individuals: • Individual #102, Individual #104, Individual #31, and Individual #37 o A sample of quarterly reviews for: • Individual #144, Individual #25, Individual #154, Individual #9, Individual #111, Individual #79, Individual #152, Individual #123, and Individual #93. Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Cynthia Martinez, QMRP Coordinator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services o Carmen Molina, Psychologist Observations Conducted: o Observations at residences and day programs o Human Rights Committee Meeting o Annual PSP meetings for Individual #5 and Individual #43
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. During the onsite review, the QMRP Coordinator reviewed the presentation book for this provision. The facility reported that it was focusing on deficits noted in Section F, but acknowledged that many of these efforts were in the beginning stages. Most of the items required by this provision were not yet fully implemented.

	According to the POI, the facility's self-rating was, in part, determined through monitoring of the PSP and PSP process by the QMRP Coordinator. The POI, however, did not include results of that monitoring. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. Many of the actions steps stated "reminded the QMRPs." There was not a compliance measure to indicate where the facility was in terms of being in compliance. Thus, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to all provisions in Section F except for F2e. The monitoring team did not find the facility to be in compliance with any of the provisions in Section F. The POI indicated that the following action had been taken to address compliance with Section F in the past six months: • The QMRP Coordinator had been trained as a trainer in Facilitation Skills for QMRPs. • All QMRPs had attended Facilitation Skills training. • The QMRP had reviewed a random sample of PSPs and quarterly reviews to determine if plans were being implemented and monitored. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style PSPs, assessments were still not completed or updated as needed, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.
	Summary of Monitor's Assessment: The QMRP Coordinator acknowledged that the facility was not yet in compliance with this provision. It was evident from conversations with the monitoring team that the facility was considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. All staff had also been trained on the new risk identification process and the process had just been implemented for some individuals at the facility. Two annual PSP meetings were observed by the monitoring team. One of the meetings was held in Spanish, the individual and his family's primary language. In meetings observed, the QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. QMRPs had recently completed facilitation training and most were still adapting the meeting process to try to capture all information needed to develop a comprehensive plan. Information regarding supports that the individuals need throughout the day was more clearly stated in the newer PSPs. As noted throughout section F, adequate assessments were not always in place to ensure all necessary supports and services were integrated into the plan. 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 meaningful 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. Quality assurance activities with regards to PSPs were in the initial stages of development. Audit tools had been developed to determine if PSPs were being developed and implemented. This was a new process at the facility and action plans had not yet been developed to address findings. 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 and then, ensuring that plans are accessible to staff. Little progress had been made towards compliance with section F since the monitoring visit in January 2011. Compliance with section F 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. The PSPs that were reviewed were chosen from among the list of individuals for whom the new format/process for PSPs had been used. The monitoring team reviewed a sample of 14 of the new plans. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in	QMRPs were responsible for facilitating PST meetings at the facility. The QMRPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. All PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings. A sample of 10	Noncompliance

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	developing, monitoring, and revising treatments, services, and supports.	PST attendance sheets was reviewed for presence of the QMRP at the annual PST meeting. At all annual meetings, there was a QMRP present. The QMRP Coordinator and one of the QMRPs had attended facilitation training in Austin. They had provided facilitation training to the other QMRPs at the facility by 5/10/11. While it was too soon to evaluate the effectiveness of this training, the QMRP Coordinator was attending annual PST meetings and continuing to mentor QMRPs with regards to meeting facilitation. For this provision to be in compliance, not only does the PSP process need to be facilitated by one person, but also team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year. This did not always occur, as indicated throughout this monitoring report. At the recent Monitors' meeting with DADS and DOJ, there was discussion regarding determining the definition and criteria for facilitation, that is, what does it mean for the QMRP to facilitate the PST in a way that meets this provision item. The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	
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.	A sample of attendance sheets was reviewed for compliance with this provision with the following results in terms of appropriate team representation at annual PST meetings. The sample included PSPs for the following individuals: Individual #36, Individual #67, Individual #164, Individual #107, Individual #10, Individual #61, Individual #184, Individual #183, Individual #69, and Individual #191. • Six (60%) of 10 indicated that the individual attended the meeting; o Exceptions included Individual #164, Individual #107, Individual #61, and Individual #69. • Seven (70%) of 10 individuals had a LAR; five (71%) participated at the annual PST. The monitoring team does not expect that all individuals or their LARs will want to attend their PST meetings. When individuals are not present for meetings, the QMRP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. Staff present by discipline where relevant at the annual PST meeting included: • In 10 (100%), the QMRP attended the meeting, • In seven (70%), staff attended,	Noncompliance

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		• In 10 (100%), day habilitation staff attended, • In nine (90%), nursing staff attended, • In seven (70%), psychology staff attended, • In three (30%), the psychiatrist assistant attended, and • In 10 (100%), appropriate PNM staff attended. The following are comments regarding participation in PST meetings for this sample. • The signature sheet for the annual PST meeting for Individual #36 indicated all relevant staff except for residential staff were in attendance at the meeting. • For Individual #67, full representation from relevant disciplines attended her annual PST meeting. • Nursing staff were not present at the annual PST meeting for Individuals #164. His PST did not reference a current nursing or medical assessment. • Given the lack of resources in psychiatry, physicians attended a limited number of PSP meetings. It was found that residential staff were not always present at meetings. These team members can provide critical input into how the individual likes to spend his or her day and what supports the individual needs. The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	
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 monitoring team found the quality of some assessments continued 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 (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, section R regarding communication assessments, and section T regarding most integrated setting practices). For example, the functional assessments were not being completed (K5), psychological assessments had not been completed for all individual (K5) and the PALS was not effective for assessing training needs (see S1). The facility had begun using the new Personal Focus Assessment (PFA). The PFA was an assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the plans reviewed, this list was individualized and offered a good starting point for plan development.	Noncompliance

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		Information gathered from the PFA was discussed in the PST meetings observed. Each QMRP reviewed the individual's list of preferences and members of the team engaged in limited discussion on how this might be supported. Attempts were made to integrate these preferences into outcomes developed by the team. Since most individuals at the facility had limited exposure to options outside of what was offered at the facility, teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Some examples where adequate assessments were not completed for the individual prior to the annual PST meeting or updated in response to significant changes included: • Individual #164's PSP indicated that he was last seen by the neurologist on 11/4/09. It further indicated that a neurology consult was requested in January 2011. The follow-up assessment had not been completed at the time of his annual PST meeting on 4/15/11. • Individual #184's PST had determined that she might benefit from an assessment from a specialist from Lighthouse for the Blind to assist with daily interactions and mobility. There was not documentation that this assessment had been obtained. • The communication assessment for Individual #69 was not updated prior to his annual PST meeting. • Individual #111's physician recommended an updated nutritional assessment following labwork on 5/11/11 that indicated her prealbumin level was low. An updated nutritional assessment was completed on 6/16/11 which referenced lab work completed on 3/7/11. The dietician did not review the lab work from 5/11/11. • Many areas of the Positive Assessment of Living Skills (PALS) assessment for Individual #107 were left blank including the summary area that identifies priority needs. All team members will need to ensure assessments are completed, updated, when necessary, and accessible to all team members prior to the PST meeting to facilitate adequate planning. The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	
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	A wide variety of assessments were performed prior to PSP development. As noted in F1c, it was not evident that assessments were always adequate to address needs or were revised as individual's needs changed. Plans developed after 1/1/11 were in the new person centered format. A sample of the	Noncompliance

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	individual.	newer style PSPs indicated QMRPs were integrating information into a more meaningful plan that identified needed supports in relation to the individual's preferences and needs. Information regarding significant diagnosis, risks, and supports, however, was not included in all plans. QMRPs were including more information in the primary narrative section of the plan, but in some cases this information was "cut and pasted" from assessments. The use of clinical terms throughout some PSP narratives would make it difficult for direct support staff to understand risks for individuals and how assessment recommendations should be implemented. PSPs should be a guide to providing supports that all staff can understand and follow. For example: • The PSP for Individual #69 included a lengthy paragraph labeled speech/audiology. Communication and mealtime information was included in this section. It appeared to be "cut and paste" information from assessments that was difficult to interpret and did not offer clear direction to staff on what supports he might need throughout his day or what his risk level might be. For instance, this section stated: "In regard to swallowing and mealtime performance, performance is compatible with mild/moderately severe oral dysphagia (affecting swallow safety due to combination of oral weakness/reduced range and significant level of impulsivity with moderately reduced effectiveness of the oral preparatory stage)." • Individual #191's annual PSP included a summary of relevant assessments and described supports that were needed throughout his day. There was a description of how he liked to spend his day, preferred activities, and important relationships. His PSP included his chronic medical issues and gave a brief description of how he should be supported to minimize his risks. Consideration was given to his independence in each area. It should be noted, however, that information in the PSP narrative reflected assessments that were current at the time of his annual PST meeting. o This individual, however, had significant changes in his medical status and numerous medical and therapy reassessments since his annual meeting. The team, appropriately, met regularly and PSP addendums documented discussions. o For minor changes, PSPAs are an effective way to update information in the annual plan. When there are significant or numerous changes in health status or supports, the PST may want to consider revising the actual PSP document with updated information to reflect current risks and support needs to ensure that staff are providing supports recommended by current assessments. With numerous PSPAs that describe revised supports, it becomes difficult to ensure that all staff	

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		have access to and are implementing the latest PSP revision The monitoring team found that PSPAs were not always filed in individual notebooks, thus, support staff only had outdated PSPs to reference when needing to verify what/how supports should be provided. • The PSP for Individual #81 stated that he was at risk for psychogenic vomiting per his SLP evaluation. It noted that this behavior is a focus of his PNMP and should staff should "continue to reduce the incidence of psychogenic vomiting through re-direction." There was not description of the behavior, when it might occur, or how staff should redirect him. 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 #69's PFA and nursing assessment noted that he had a hernia and had been referred for surgery. His PSP did not reference a hernia or any supports that might have been needed to minimize risk of injury. ▪ Assessments for Individual #107 indicated that he had limited communication skills. Communication outcomes were not developed by the team to improve his ability to make his needs known. His skill acquisition plans noted that he was nonverbal but did not include communication strategies to use when implementing outcomes. ▪ Assessments for Individual #31 indicated that it was difficult for her to express her opinions or preferences. She did not have a guardian or family member involved in helping her to make decisions. The team did not address her need for guardianship. Additionally, the team did not discuss her communication skills or how staff should support her communication needs. She had an outcome to continue to use her communication dictionary and communication boards, but strategies for communication were not integrated into her other training objectives. Plans offered little indication of how each individual spent a majority of the day. A description of each person's day along with needed supports identified by assessment should be included in PSPs. The facility was in the beginning stages of ensuring assessment information was used to develop plans that outlined all supports and services. The QMRP Coordinator recognized the challenges in achieving compliance with this provision and was working with QMRPs to ensure progress in this area. The facility's POI indicated that a sample of PSPs and quarterly reviews were reviewed by the QMRP Coordinator and findings indicated not all	

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		recommendations from assessments were implemented and monitored. The facility is not yet in substantial 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).	A sample of 10 PSPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement as required. All 10 (100%) indicated that this discussion took place at the annual PST meeting. In 7 of 10 (70%) instances, the teams concluded that the individual should continue to reside at EPSSLC. As evidenced by the summary below, this discussion was not always adequate (also see section T of this report). • Individual #16's PSP indicated that his parents did not want to explore community placement. The team agreed that his current home was the most optimal placement. There was no discussion regarding his needed supports and preferences in determining optimal placement. • The PSP for Individual #31 indicated that the team had discussed optimal placement and some team members felt that continued placement at EPSSLC was optimal while others though community placement might be optimal. The PSP discussion concluded with "she would probably do well in the community as long as all the services and supports were in place for her." There was no indication that the team planned to explore this further. • Individual #81's PSP indicated that the PST had determined placement at EPSSLC was optimal placement because his behaviors required 1:1 supervision. The plan further stated, "he does not interact with people so this shows he really doesn't have an interest in socializing in the community." The team did not consider that he could be supported with 1:1 supervision in the community or that he might have to interact less socially in a smaller home with fewer housemates. • Individual #66's PSP indicated that his guardian was opposed to community placement. The team agreed that placement at EPSSLC was optimal since the guardian did not want community placement. There was no discussion around where his needs could be better met. • The PST for Individual #21 determined that the optimal setting was EPSSLC. Her being below her optimal body weight was listed as an obstacle that needed to be addressed before community placement could be considered. The team did not address the fact that she was unable to maintain her current weight at EPSSLC so necessary supports may not be in place there either. • The PST for Individual #107 determined that optimal placement was EPSSLC. There was no discussion regarding how his needs could be met in a more integrated setting. • Individual #67's PST determined that EPSSLC was optimal placement for her. It appeared that the team had a thorough discussion regarding her dislike for	Noncompliance

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		change in her environment. As noted during the previous monitoring visit, the CLOIP MRA assigned to the facility was not well informed regarding her role and community living options. In the PST meeting observed during the monitoring visit, the QMRP led a good discussion regarding community living. The CLOIP MRA was present at the meeting but contributed very little to the discussion. The family was against community placement though the team agreed that it would be a good option for the individual. The QMRP offered additional information to the family and attempted to educate them on options in the community. This should have been the role of the CLOIP MRA. The facility needs to address this with the contract MRA agency. Plans still included limited opportunities for community based training. Opportunities to develop relationships and gain membership in the community were not addressed in any of the plans in the sample. Although the facility reported that some training was occurring in the community, it was not evident in PSP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. 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. He was working in the community, but had lost his job since the last monitoring team visit. The monitoring team recommended during the last review that 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. There was very little focus on community integration at the facility and teams did not have the knowledge needed to develop plans to be implemented in the least restrictive setting. The facility needs to provide additional training to teams in this area. This was also noted in the previous monitoring report. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	
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		

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	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 continued to include a list of "What's most important to the person?" For individuals in the sample, this list was used as the basis for outcome development. Limited exposure to new activities meant that this list was often limited. As noted in F1e, outcomes were not functionally implemented in the community. There was very little focus on priority skills such as communication, socialization, and community integration. The PSTs should have developed action steps that would facilitate community participation while learning valuable skills needed in the community for most individuals in the sample. Currently, little structured training was occurring in the community. The facility had few options to address vocational services. Training in the vocational areas focused on continuing to work on a limited choice of available contracts. There were no individuals employed in the community and outcomes in PSPs reviewed did not address exploring community employment for those individuals currently served in the vocational program. 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 wages in an integrated setting. Progress made on each vocational outcome should move the individual closer to community employment. It did not appear that was a real consideration for the individuals in the vocational program. Work outcomes tended to be just a continuation to work without any measurable outcomes to improve or learn new work skills. • For example, Individual #10's PSP noted that work was important to him, but did not include information about what skills he might need to pursue community employment. He had a work related outcome to choose a task from a group that he enjoys doing, such as ground work, sorting and shredding paper, and washing cars. It was not clear how this would develop more functional job skills. The measure of success was based on choosing a task, not how well he completed the task, which would be an essential employment skill. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Meaningful supports and services were not put into place to encourage individuals to try new things in the community.	Noncompliance

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		It was not always clear how outcomes were related to the priorities and preferences of individuals in the sample of PSPs reviewed. For example, • Individual #10 had four training objectives to increase his independence. One was to insert money in a slot to pay for his bus ride and another was to work on connecting the dots of his first name to sign his name. Neither of these was identified as priorities for moving him closer to achieving independence in relation to his stated preferences. The other two training objectives for showering and learning to use his TV remote control related to his preferences for looking nice and watching TV. • Individual #183 was scheduled to move into the community. Her PSP indicated that she loved to socialize and engage in activities with others. Her outcomes did not include a plan to support her in building new relationships in the community. It did include an outcome to identify the EXIT sign located in her dorm. She was not ambulatory and did not self propel her wheelchair. She would need total assistance to leave the building in an emergency, so this was not a priority for her. It was noted in the previous monitoring visit that there were limited opportunities for leisure and recreational activities in the evening that encouraged functional learning, communication, and socialization opportunities. A tour of the residences during this monitoring visit revealed that there had been some progress made in this area. Better interaction and more meaningful activities were occurring in two of the cottages visited. • There had been a focus by the facility on providing more meaningful active treatment in Cottage #506 where a majority of the behavioral incidents were occurring. This focus had resulted in creating a much more relaxed atmosphere. During observation, the individuals in that home were engaged in activities that they enjoyed and staff were actively engaged with the individuals. Observation at other cottages and dorms revealed that many individuals at the facility were still engaged in nonfunctional isolated activities with very little interaction, such as working puzzles and coloring pictures during the evening hours. The facility had expanded the focus for active treatment to two other cottages, but was in the beginning stages of this plan. The monitoring team looks forward to seeing progress in this area during the next monitoring visit (also see section S below). PSPs reviewed were still 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	

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		individuals to try new things. The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. 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 measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. See section T1b for additional comments related to this requirement. The facility's POI indicated that they were not yet in substantial compliance with this item. The monitoring team agrees with that assessment.	Noncompliance
	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 still not being 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. The newer plans were much more comprehensive in identifying and addressing risk for individuals and including supports that were needed by each individual. See section I of this report for specific examples of how risks were being identified and addressed in plans. 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. Then the facility must ensure that plans are developed and implemented in a timely manner. As noted throughout section F, the planning process did not always result in a plan being developed and distributed to staff responsible for implementing 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's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	Noncompliance
	4. Identifies the methods for	For the goals and objectives identified, PSPs generally described the timeframes for	Noncompliance

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	implementation, time frames for completion, and the staff responsible;	completion, and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The facility had made little progress towards compliance with this item. As noted throughout the report, outcomes in the PSPs reviewed did not always adequately address supports needed by the individual to achieve outcomes and strategies to support functional learning were not included in the PSPs in the sample. As noted throughout other sections of this report, there is need for improvement in the development of plans to address risk for individuals, psychiatric treatment, healthcare issues, PNM needs, and behavioral support needs. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. The facility had divided individuals into groups to attend day programming. Each group rotated through program areas such as bed making, table setting, and transportation. The training provided in these areas would have been more functional in a natural setting, such as the home or community. Individuals in each group worked on training that was a focus of that group rather than a priority for that individual identified by the PST.	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.	SPOs generally 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 quarterly progress note and QMRP would monitor implementation. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, section L and M for the collection and review of medical and nursing indicators, and, section P and O for data collection relevant to physical and nutritional indicators.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	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 G, 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. As noted in F2g, the facility did not have a fully developed quality	Noncompliance

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		assurance system in place to effectively monitor the quality of PSPs. The monitoring team found a lack of coordinated supports and services throughout the facility. Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. As discussed with the facility during the monitoring visit, PSTs will need to work together to develop and revise plans as needed. This was not consistently occurring. The facility did not have a process to ensure coordination of all components of the PSP.	
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 individual records was reviewed in various homes at the facility. Current PSPs were not available in 56% of 33 records, indicating that support staff did not have information necessary to fully implement PSPs. This was noted to be a problem during the last monitoring visit. Action had not been taken by the facility to address this finding. The facility needs to implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. The PSP is a document that is integral to overall service provision, and ensuring it is available in the record seems to be a relatively easy clerical task. As noted throughout this report, plans were not always written to ensure that staff would know how to consistently provide all necessary supports. The facility remained out of compliance with this requirement.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in	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 team members took action or revised plans when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate outside of schedule quarterly review meetings. The facility had a quarterly review process in place to look at progress towards outcomes; changes in health and behavioral status; therapy recommendations; level of supervision; injuries and restraints; family; and participation in community and social activities. While this was not occurring monthly, this was a good start to achieving compliance with this provision. The facility will need to implement a system to monitor services and supports monthly and ensure that plans are revised and updated as necessary. When plans are revised, there needs to be a system in place to ensure that all support staff are aware of changes and new plans are being implemented as written.	Noncompliance

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	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 sample of quarterly review documentation was provided to the monitoring team The form included a section to note progress or regression on all service and training objectives monthly and along with a place for QMRPs to comment quarterly on the progress or lack of progress. Each discipline gave a brief summary of any progress or regression throughout the quarter. A sample of quarterly reviews was reviewed for compliance with this provision. Data was not consistently described in the section of the quarterly review that summarized progress on training objectives. Some reviews listed a percentage of successful attempts, others listed a number for each month of implementation (it was not clear if this was the number of times the outcome was implemented or the number of successful trials), and others included both the number of trials and the percentage of successful attempts. It was not always clear how the team addressed the lack of implementation, lack of progress, or need for revised supports. The following are examples of findings from the sample of quarterly reviews reviewed: • The quarterly review for Individual #111 for 3/1/11 through 5/31/11 included information from all disciplines regarding progress and changes in healthcare and behavioral status. It was not evident that the team addressed regression as needed throughout the quarter. The team met to address a number of falls in March 2011. At that time the team agreed that she needed to be evaluated by the psychiatrist to see if the falls were related to changes in her medication. In April 2011, two more falls were recorded, but there was no documentation in the quarterly review of an assessment by the psychiatrist. In May 2011, the team met again to discuss changes in behavior. There was no indication that the QMRP followed up on an assessment by the psychiatrist. The psychiatrist noted that the individual responded well to Haldol, but had experienced mild unsteadiness. She had experienced several significant falls, however, it did not appear that the team had discussed this with the psychiatrist. • The quarterly review for Individual #144 for 1/1/11 through 3/31/11 indicated that several outcomes had been completed in January 2011 and needed to be revised. This should have been noted in the monthly review of outcomes and outcomes should have been revised the following month. • The pharmacist assessment included in the quarterly review for Individual #154 for 2/1/11 through 5/31/11 noted that she had experienced chronic constipation during this quarter. It was further noted that she had been on milk of magnesia since 12/3/10, which is not typically indicated for long term use. There was no indication that this was addressed by the team. • The quarterly review for Individual #9 dated 11/1/10 through 1/31/10	

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		indicated that she had regressed from a 100% success rate to 0% success rate the following two months. The QMRP noted the regression, but there was no explanation for the sudden decline in skills. The review also noted that psychology and nursing did not complete their section of the quarterly review. There was no documentation of follow-up by the QMRP. 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. Plans should be updated and modified as individuals gain skills or experience regression in any area. QMRPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues. Recommendation throughout this report regarding implementation and monitoring of treatments should be considered when developing the PSP.	
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 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. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written The facility's POI indicated substantial compliance with this requirement. The monitoring team did not agree with that assessment. Although staff had received required training on the PSP process, it was not evident that this training was competency based. The monitoring team understands that additional consultative support, training, mentoring, and coaching were going to be provided over the next few months.	Noncompliance

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F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Of PSPs in the sample reviewed, all (100%) had been developed within the past 365 days. As noted in F2c, a sample of 33 plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 56% of the plans in the sample were not current. Some plans were over a year old indicating that in some cases, PSPs may never have been distributed if developed. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have information regarding services, risks, and supports for individuals in the home. Without it, staff did not have the tools that they needed to safely and consistently support individuals. Additionally, as noted throughout this report, plans were not always revised as needed. The facility was rated as being out of compliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility had a tool to monitor PSPs to ensure the development of a comprehensive PSP that addressed all services and supports. Quality enhancement activities with regards to PSPs were still 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. QMRPs should be held responsible for not distributing plans in a timely manner and support staff should be trained to notify supervisors when they do not have the tools necessary to safely and consistently provide supports. An effective quality assurance system for monitoring PSPs was not in place at the facility.	Noncompliance

Recommendations:

1. QMRPs should ensure that direct care staff has current information needed to support each individual safely and consistently, and that all plans are being implemented as written. (F1, F2a3, F2c)
2. Develop a system to ensure that PSPs are in individual records and updated as necessary. (F2c)
3. When key members of the PST are unable to attend meetings, document any attempts to get input prior to the meeting and include recommendations from each team member not present. (F2b)
4. A description of each person's day along with needed supports identified by assessment should be included in PSPs. (F1d)

5. Provide additional training to PST members on developing and implementing plans that focus on community integration. (F1e, F2a)

6. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed. (F1e)

7. The facility needs to consult with the state office to provide clarification on issues surrounding community placement for individuals placed at the facility in order to hold an informed discussion during PST meetings regarding proceeding with community placement (see section T). (F1e)

8. Address barriers to participating in integrated work and day programming. Ensure meaningful supports and services are put into place to encourage individuals to try new things. (F2a)

9. Additionally, teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. (F2a2)

10. Ensure PSTs meet and hold integrated discussions to develop and revise plans as needed. (F2b, F2f)

11. Plans should be updated and modified as individuals gain skills or experience regression in any area. QMRPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues. (F2b, F2d)

12. Implement a quality assurance process for assessing whether PSPs are developed consistent with this provision. (F2g)

13. Work with the CLOIP MRA staff person regarding more active participation in the PSP meeting. (F2e)

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, undated, but current o EPSSLC policy lists, 4/8/11 o List of typical meetings that occurred at EPSSLC o EPSSLC POI, 7/1/11 o EPSSLC Sections G and H Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/11/11 o QAQI Council meeting minutes listed in section E above o Review of records listed in other sections of this report Interviews and Meetings Held: o Jaime Monardes, Facility Director o Dr. Ascension Mena, M.D., Medical Director o Residential Unit Director: Jeff Moody o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 7/13/11
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the medical director wrote a sentence or two about what tasks were completed and/or the status of each provision item. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The medical director self-rated the facility as being in noncompliance with both provision items. The monitoring team agreed with these self-ratings.

	The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). It did not seem that the action steps for G1 would sufficiently bring the facility into substantial compliance. The facility will need to take a thorough and thoughtful approach to meeting the requirements of this provision. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: EPSSLC was not in compliance with this important provision and was not yet taking serious action to address it. The medical director was the lead for this provision, however, he joined the facility very recently and, therefore, it was not surprising that this provision was not his first priority, given the many other important medical service tasks to which he needed to attend. The monitoring team recommends that the facility director consider taking the lead for this provision (and provision H, too). Some specific examples were provided to, or observed by, the monitoring team that showed some ways in which clinical services were provided in an integrated manner. More so, however, there were a number of areas in which integrated services could be, but were not being, provided. A draft of a state policy was reviewed. It addressed a combination of the requirements of both provisions G and H. The content related to section G, however, was merely a restating of the wording from the Settlement Agreement and will, most likely, be insufficient to guide the facility. As a result, the monitoring team recommends specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.

#	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	EPSSLC was not in compliance with this important provision and was not yet taking serious action to address it. The medical director was the facility's lead manager for this provision (as well as for provision H). Given that he very recently joined the facility and had numerous other responsibilities in providing medical care, supervising medical care, and putting in place systems of health care, as well as learning about the DADS ICFMR regulatory and Settlement Agreement processes, it was not surprising that this provision (and provision H) were not given prioritized attention. Therefore, the monitoring recommends that the facility director take the lead in these two provisions, at least for the next six to 12 months. Perhaps this might also become a	Noncompliance

#	Provision	Assessment of Status	Compliance
	receive the clinical services they need.	performance improvement project (see section E). Partnering with one or more other SSLCs might also prove helpful to the facility director. DADS central office may be able to assist in getting this set up. To assist all of the facilities in achieving substantial compliance with this provision, the monitoring teams recently presented to DADS and DOJ a listing of activities in which the SSLCs might engage that would indicate the occurrence of the provision of integrated clinical services. This list (i.e., criteria) was being reviewed by DADS and it is expected that over the next several months, this list will be finalized and can be used by each facility. This list might also become part of the self-monitoring of section G compliance. At the time of this onsite review, the facility was not engaging in any self-monitoring of sections G or H. It will be important for EPSSLC to do self-monitoring of these two important provisions if substantial compliance is to be achieved and maintained. <u>Policy</u>: A facility policy did not exist, however, a draft DADS statewide policy was available. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. <u>Monitoring team examples</u>: Examples of integration of clinical services were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • Integrated progress notes were being used. • The nursing and pharmacy departments, and the medical and psychiatry departments appeared to be working well together. • In the most challenging of cases, when individuals displayed serious behavioral problems or very complicated medical issues, the many clinical disciplines eventually came together and worked in an integrated manner (e.g., Individual #13, Individual #2). • A neurology-psychiatry clinic was occurring each month. For those individuals who were seen in neurology clinic, there was an accompanying psychiatric notation indicating collaboration and review of the information. • The medical director said that he planned to begin having a regularly occurring	

#	Provision	Assessment of Status	Compliance
		meeting with the dental department. • The medical director reported meeting with pharmacy director at least twice a month to discuss medial-pharmacy issues. • The medical director said that he had a schedule of PST meetings. The QMRPs notified him of each meeting and he or the nurse practitioner were planning on attending meetings. The monitoring team observed the medical director or the nurse practitioner at various PST meetings during the week of the onsite review. • The facility has begun interdisciplinary active treatment meeting to improve individual engagement. Active treatment meetings began in May 2011 and included the unit director, incident manager, nurses, and QMRPs. The medical director also participated in this meeting. • The facility has begun interdisciplinary data collection meeting to assess, and potentially reduce, the data DCPs collect. • The facility director had placed psychologists, QMRPs, and other administrator offices in the homes and talked about administrative staff becoming more visible in the homes. • The medical director had taken several steps to improve relationships with local hospitals. He was working on an agreement to arrange for direct admission to the hospital. He also was exploring ways to have GYN exams completed by physicians from the local medical center. Other examples indicated that more work needed to be done: • There was no daily clinical meeting with the medical staff (PCPs, APRNs, psychiatrists, and dentist), nursing, and the hospital liaison. Such a meeting would provide an opportunity to discuss events of the last 24 hours, particularly events that occurred after hours. • The PSPs of 19 of the 20 individuals reviewed failed to integrate their health needs and risks and ensure that they received the clinical services they needed. • When/if an individual's PST made recommendations for development of health care plans to ensure that the individual received the clinical services he or she needed, there was no evidence of follow-up to ensure that the plans were developed, implemented, and evaluated for their effectiveness. • Psychiatry was beginning to integrate with other disciplines primarily due to other disciplines attending psychiatry clinic more regularly. Consideration should be given to psychiatry participating in other discipline's activities, as appropriate. • Observations of psychiatry clinic revealed challenges in consultation and collaborative efforts with psychology. It was apparent that both disciplines were unsure as to what information could be obtained from, or provided to, the other. • There were problems with the data provided to the psychiatrist during the	

#	Provision	Assessment of Status	Compliance
		clinical encounter (e.g., outdated, inappropriately graphed). • There was very poor collaboration among departments in the developments of SPOs, such as psychology, habilitation, and speech and language. • Disciplines needed to work together to address desensitization programming. • 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.	
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.	As noted in the previous monitoring report, the facility appeared to be responsive to recommendations from non-facility clinicians. This provision item requires that there by an explicit statement, in the integrated progress notes, of the PCPs' agreement or disagreement with each of these recommendations, and the requirement to refer relevant information to the PST. The medical director reported that consultations were reviewed, and that each consultation form was stamped upon receipt. A full and consistently implemented process to address this provision item, however, was not yet in place. This included the absence of a system for tracking consults. All consults were forwarded to the medical office for review by MD or APRN. It was reported that an entry was made in the IPN for every consult received. This was not evident in the sample of records reviewed by the monitoring team (section L). 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 (section M). In addition, there were several instances when nurses recorded and communicated incorrect/erroneous information regarding individuals' diagnoses during their hospitalizations to facility clinicians. There was no evidence that these errors were identified and corrected. The medical department should maintain a report log that lists all non-facility consultations and tracked them from the date received until the final report was obtained. This listing might be useful to the recordkeeping department for their conduct of quality assurance reviews of the active record (see section V3 below).	Noncompliance

Recommendations:

1. Consider having the facility director be the lead for provisions G and H.
2. Develop and implement policy.
3. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring.
4. Develop a system to assess whether or not integration of clinical services is occurring (i.e., self-monitoring). This will require creating measurable actions and outcomes.
5. Address the items above in G1 under "Other examples indicated that more work needed to be done."
6. Consider the inclusion of a statement regarding the integration of clinical services in each individual's PSP document.
7. Put in place a system for addressing G2.
8. Develop and maintain a list of all non-facility consultations, per individual.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, undated, but current o EPSSLC policy lists, 4/8/11 o List of typical meetings that occurred at EPSSLC o EPSSLC POI, 7/1/11 o EPSSLC Sections G and H Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/11/11 o QAQI Council meeting minutes listed in section E above o Review of records listed in other sections of this report Interviews and Meetings Held: o Jaime Monardes, Facility Director o Dr. Ascension Mena, M.D., Medical Director o Residential Unit Director: Jeff Moody o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o QAQI Council Meeting, 7/13/11
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the medical director wrote a sentence or two about what tasks were completed and/or the status of each provision item. All of these were dated in May 2011 or June 2011. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The medical director self-rated the facility as being in noncompliance with all seven provision items. The

	monitoring team agreed with these self-ratings. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Further, it did not appear that the actions listed in the action steps would be sufficient to meet the broad requirements of each of the items in this provision. For example, there were no action steps for H1, H2 action steps did not refer to any diagnostic criteria, the H3 action steps only referred to sick call and an annual assessment, and the H4 and H6 action steps did not indicate if other protocols would later be added. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: Similar to provision G, not much progress was observed in regards to this provision item due, in large part, to the assignment of this provision to the very new medical director. As also recommended for provision G, the facility director should consider taking the lead role on this provision, too. A draft state policy was disseminated. Although it was not yet completed, it provided some detailed guidance to the facility regarding provision H (but not for provision G as noted above). It will be important for the facility to include all clinical services, not only medical services, as it works towards addressing the requirements of 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.	An overall facility plan was not in place to address provision H of the Settlement Agreement and, therefore, a plan was also not in place to address this provision item. That is, 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 across all areas of clinical service. As noted above in section G, the medical director was also responsible for provision H. The monitoring team recommends that the facility director consider becoming the lead for this provision, at least for the next six to 12 months. When addressing provision H, the facility will need to ensure that all clinical services are addressed, not only nursing and medical.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For this provision item, H1, the state policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). The medical staff conducted sick call daily based on the assigned caseload. Assessments were usually in response to acute changes or hospital returns. There were, however, many lapses in follow-up to ensure that individuals who were "put on the clinic list" were actually seen, and if/when seen, that the clinical professional's recommendations were implemented in a timely manner. As noted in section M below, 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. 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. The facility psychiatrist had completed three comprehensive assessments. As stated in J2 and J13 below, there was need for substantial improvement in this documentation, collaborative case conceptualization, and integrated treatment planning with psychology or other disciplines. As noted in section K, below, psychology assessments were not consistently completed and functional assessments were not completed for the majority of individuals with PBSPs. Assessments were generally conducted on an annual basis by OT and PT and issue-specific consults were completed upon referral or change in status generally in a timely and consistent manner related to OT, PT, and SLPs. Annual assessments were conducted for communication, but not typically seen relative to changes in status.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the	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. Even so, record reviews by the monitoring team indicated that appropriate ICD 9	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	nomenclature was used. For psychiatric diagnoses, documents reviewed by the monitoring team showed brief, unsatisfactory reviews of the diagnostic criteria/symptoms that an individual was experiencing, such that a specific diagnosis was assigned. A review of psychology documentation for these same individuals provided greater detail regarding diagnostic criteria, medication risks/benefits, and interventions. This indicates the need for improved collaboration between the disciplines, such that a collaborative case conceptualization can be developed. Nursing assessments consistently failed to accurately reference complete lists of the individuals' "active medical problems." None of the 20 sample individuals' (section M) nursing assessments resulted in complete or accurate lists of nursing diagnoses, in accordance with NANDA.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	EPSSLC did not have a plan or procedure in place to ensure or monitor 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 across all clinical service areas. Facility self-monitoring might include an item indicating whether there were any examples of interventions being clinically inappropriate and/or provided later than clinically appropriate. The medical staff responded to changes in status by conducting assessments and providing treatment. For the most part, the responses appeared to be timely. In psychiatry, increased collaboration with psychology and nursing would be appropriate, specifically with increased attention to non-pharmacological interventions. Across 19 of the 20 sample individuals (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. The one exception was the failure of Individual #10's clinical professionals to ensure that the significant changes in Individual #10's health status evidence, which included signs/symptoms of possible contagious, infectious disease, were adequately and consistently assessed and monitored and/or that interventions were implemented and follow-up activities occurred in a timely manner to ensure the health and safety of Individual #10 and those who were in contact with him. Many of the intellectual assessments in the psychological assessments were over 5 years old (section K).	Noncompliance

#	Provision	Assessment of Status	Compliance
		The interventions by OT and PT appeared to be appropriate, however there were a number of individuals who were deemed to not require intervention beyond the PNMP because they "performed at baseline." The concept of skill acquisition is intended to move the individual along the continuum of learning not to merely maintain skill levels at baseline. More discrete evaluation strategies would yield further areas of potential for skill acquisition for a number of individuals and these could be integrated into existing programs or additional SPOs, designed and directed by the therapy clinicians with implementation by home, day program or work staff.	
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.	The draft state policy included a relatively long list of data for the facility to collect and monitor in areas of medical staffing, timeliness of actions, equipment and resources, quality of care severity indices, expected death rates, morbidity, clinical indicators for a variety of conditions, diabetes care, and patient satisfaction. This looked like a good start to assist the facility in meeting this, as well as the other, items of provision H. 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. The facility had not implemented any clinical guidelines at the time of the review. A list of eight were in the POI. It was not clear if this was an initial goal or if the list would eventually include a greater number of clinical protocols. There were very few intervention plans developed by OT, PT, and speech. In the case of speech, there were no current SPOs, documentation was absent, and these were not outlined in the PSP as training objectives. In the case of OT and PT, many of the goals were not measurable in the sense that they did not include performance criteria.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A plan was not in place to address this item and, therefore, this item was rated as being in noncompliance. Recently, the way in which the facilities determined and managed risk was overhauled. The health status team system was discontinued and managing risk was incorporated into the PSP process (see section I below). 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The activities noted in the draft state policy commented on above in section H4 also apply to this provision item. Health status was monitored through the periodic assessments completed by multiple disciplines. Medical providers completed comprehensive annual assessments. Additionally, quarterly medical assessments were completed to review the most recent events. Quarterly Drug Regimen Reviews also contributed to the monitoring of health status. The clinical pharmacists reviewed laboratory results and diagnostics as required by the facility's lab matrix. Recommendations generated by these reviews were forwarded to the medical providers. Although members of nursing leadership (nurse managers and nurse supervisor) reported that they conducted regular monitoring of individuals' health status, vis a vis daily "rounds," across all 20 records reviewed (section M), there was no evidence that rounds were made regularly and as needed and no evidence that observations were consistently reported, recorded, and/or acted upon in a timely manner. As health status had been folded into the PST process, and psychiatry was not a regular attendee, there was cause for concern that the health status with regard to specific psychiatric indicators was not appropriately monitored.	
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. A comprehensive set of clinical indicators had not been established. Numerous clinical guidelines were being reviewed at the state level. The POI listed 10 clinical protocols (though the POI listed 8 under H4). Despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, the majority of the individuals' HMPs and ACPs were not revised, and they did not reflect the most current conditions and intervention strategies. PBSPs had begun to be modified based on individual behavior, but much work still needs to be done in this area (section K).	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with	Policies, procedures, and guidelines were not in place regarding Section H and, therefore, this provision item was found to be in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	State policy was in draft and incomplete format.	

Recommendations:

1. Consider having the facility director be the lead for provisions G and H.
2. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H.
3. Ensure that all clinical services are addressed by the facility, not only medical activities.
4. 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.
5. 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:** <u>Documents Reviewed</u>: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o EPSSLC Policy #006.2: At Risk Individuals dated 4/26/11 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 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 Aspiration Pneumonia/Enteral Nutrition Evaluation Form 12/29/10 o Aspiration Triggers Data Sheet o EPSSLC POI for Section I o List of individuals seen in the ER or hospitalized since 7/1/10 o List of individuals with fractures since 1/1/10 o List of individuals with pneumonia incidents in the past 12 months o List of 10 individuals with the most injuries o List of all individuals residing at EPSSLC determined to be high or medium risk in any area o List of individuals at high risk for respiratory issues o List of individuals at high risk for choking o List of individuals at high risk for GI concerns o List of individuals at high risk for aspiration o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals with poor oral hygiene o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o List of top ten individuals causing peer injuries for the past six months. o List of Incidents and Injuries since 1/1/11 o PSPs and relevant assessments for determining risk: • Individual #21, Individual #161, Individual #61, Individual #184, Individual #13, Individual #67, Individual #36, Individual #191, Individual #69, Individual #16, Individual #10, Individual #104, and Individual #37 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Mario Gutierrez, Incident Management Coordinator

	o Cynthia Martinez, QMRP Coordinator o Gloria Loya, Human Rights Officer o Valerie Grigg, Director of Behavioral Services o Aurora Rosa, QMRP <u>Observations Conducted</u>: o Observations at residences and day programs o Morning Unit Meeting 7/11/11 and 7/14/11 o Incident Management Review Team Meeting 7/12/11 and 7/14/11 o Human Rights Committee Meeting o Annual PSP meetings for Individual #5 and Individual #43 o PST Integrated Risk Rating demonstrations/discussions for Individual #93
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. In addition, during the onsite review, the Dr. Mena reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed (i.e., At-Risk policy was implemented). The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to each of the three provision items in section I. The facility acknowledged that it was in the initial stages of implementation of the new at risk process that was designed to meet the provisions of section I. The monitoring team was in agreement with these self-ratings. It was unclear from a review of the POI how EPSSLC came to this self-rating. The action steps included in the POI were restatements of the requirements of this provision.
	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. The new policy included changes in evaluating and addressing risks identified for individuals. • Forms had been revised for identifying risk, and a risk action plan had been developed. • Risk Guidelines had been developed to be used by PSTs in rating risk factors. • A new initiative had been implemented to address aspiration pneumonia. A tool had been

	developed to identify individuals at risk for aspiration. The at-risk process underwent significant revision designating each individual's PST responsible for risk assessment and management, as well as ongoing risk review and addressing changes in status. Not only would the PST identify health and behavioral risks and their level of severity, but would assure appropriate plans were developed and implemented as planned in order to reduce risks and improve quality of life. The revised at-risk process identified collaboration and assistance with the BSC and PNMT in developing plans for individuals at high risk, who were not stable or for whom the team has requested assistance. EPSSLC had taken minimal steps towards compliance with this provision including: • 90% of employees had attended webinar training on the at risk policy in February 2011. • Implementation had begun of the new risk action plan for individuals determined to be at risk. Health care plans were being developed from the risk action plans. • Risk levels were being entered into the statewide database. As noted throughout Section I, the monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. All staff needed to be aware of and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The 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 regularly scheduled next quarterly PST meeting beginning in February 2011. 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. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee. A list of indicators for each of 21 risk areas had been identified by the new state policy. Each was to be rated according to how many risk indicators applied to the individual's case. A risk level of high, moderate, or low was to be assigned for each category. The facility had identified a target list of individuals with a history of pneumonia and/or aspiration pneumonia and/or received enteral nutrition as priority individuals for identification of aspiration risk. Eleven individuals at the facility had been identified as high risk for aspiration and twelve were rated as medium risk.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A list of all individuals diagnosed with pneumonia at the facility indicated that four individuals had been hospitalized due to pneumonia/aspiration pneumonia since 1/1/11. Of the three that were released with a diagnosis of aspiration pneumonia, only one was identified as being high risk for aspiration. Twenty-four individuals at the facility had been rated as being high risk in one or more categories. No individuals were identified as being at high risk for skin integrity issues or hypothermia. The monitoring team met with the PST for Individual #93 during the review week to observe and discuss how the teams assigned risk ratings. The monitoring team was impressed with the QMRP's knowledge of this case and, further, appreciated the PST's willingness to conduct this type of discussion with the monitoring team. In this meeting, the team reviewed the list of risk areas that had been developed by the state office. Comments from the monitoring team are summarized below: • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. • The interrelatedness of risk factors should be considered and discussed in an interdisciplinary fashion. • Action plans should reflect the PST's thinking of additional supports above what is regularly provided for the categories rated at higher risk. • Teams should be thinking about characteristics that put an individual at risk (i.e., statistical at risk) rather than just reviewing their personal history of experiencing the identified problem (e.g., someone might be at high risk for aspiration even if he or she has never had the problem). • The action plan should indicate where the PST is headed in terms of supports, not to serve as documentation of what has been completed. • Even though PSTs were making progress in incorporating at-risk discussions into the annual PSP meeting, it was not as evident during other as-needed times, such as during PSPA meetings. Observation of annual PSP meetings scheduled the week of the review showed that PSTs had just begun this new process and were still experimenting with how to integrate the new risk identification process with the new PSP development process. QMRPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the process appeared to be similar to the process that Health Status Teams were using during previous observations. The team briefly read over the indicators for each risk and corresponding disciplines assigned the rating based on the state guidelines. There was little integrated discussion from the team.	

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		During observations of two PST meetings, both RN case managers came to the meetings unprepared to discuss the individuals health risks, and, as a result, delayed the evaluation, planning, and implementation of plans to address significant changes in the individuals' health needs and risks. A sample of PSPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by PSTs. The following are examples where risks were not consistently identified in documents reviewed. • Risk ratings were not identified in the PSP for Individual #21. She was not listed as being at medium or high risk on the facility's overall rating list. According to assessment information, however, she was at risk for weight loss, choking, aspiration, skin integrity, contractures, osteoporosis, and fractures. She was hospitalized 1/7/11 for aspiration pneumonia. The full team needs to meet and determine her true risk levels and develop a plan to address all risks. ▪ Individual #61's assessments indicated that she had a number of risks that should be monitored including seizures, oral hygiene, osteoporosis, constipation, hyperlipidemia, obesity, GERD, and she was at risk for injuries. Her PSP did not indicate that adequate discussion had taken place regarding those risks. It was not evident that plans were implemented to minimize her risks. She was not included on the facility's high or medium risk list. • Individual #13 was not identified on the facility's list of individuals at high or medium risk in any area. His assessments indicated that he was at high risk for challenging behaviors and injury. Additional areas of risk identified by assessments were osteopenia, choking, constipation, skin integrity, polypharmacy, and seizures. An Aspiration/Choking Risk Screening Tool was completed on 3/22/11 indicating that he was at medium risk for aspiration. • Individual #36 was not identified on the facility's list of individual at high or medium risk in any area. He had seizures that uncontrolled by medication and had been seen at the hospital on 4/6/11 and 4/9/11. His PSP also indicated that he was at risk for falls, injuries, aspiration, choking, osteoporosis, and challenging behaviors. A Risk Screening Tool was completed on 4/10/11. It did not include other risk that may affect his overall risk rating. • Health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. The review of 20 sample individuals' records (section M) revealed that only two individuals had complete, current, and accurate risk screening assessments. Numerous additional examples are listed in section M5. The facility's POI indicated that the facility had given itself a noncompliance rating for	

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		this provision. The facility was not yet in compliance with this provision of the Settlement Agreement. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor risks.	
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 high risk, or if referred by the PST, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. 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 documented. 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 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.	Noncompliance
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	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. The new policy required 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. Throughout the monitoring visit, direct support professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff were not able to accurately identify health care risk for the individuals who they were supporting. Some staff mentioned behavioral risk and a few named risks, such as falls or seizures when probed further, but none could identify present diagnosis and how those diagnoses should be monitored to avoid risks. As noted throughout this report, intervention plans	Noncompliance

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	plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	were often not carried out as written, therefore, individuals remained at risk. 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 or not accessible, so direct support staff did not have current information regarding risks available to them. 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. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility POI indicated that the facility was not in compliance with this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. 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.

2. The facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.

3. Ensure that risk rating accurately reflect risks identified through the assessment process.

4. Update facility risk list to include ratings assigned by each PST.

5. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk.

6. 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 Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, nurses notes, psychiatry notes associated with the incident, documentation of any PST meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Ten examples of desensitization plans (five for dental and five for medical) o Any auditing/monitoring data and/or reports addressing the 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 Individuals prescribed psychotropic/psychiatric medication, and for each individual: name of individual; name of prescribing psychiatrist; residence/home; psychiatric Diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact (note the dates the individual was seen in the psychiatric clinic for the past six months and the purpose of this contact, for example: comprehensive psychiatric assessment, quarterly medication review, or emergency psychiatric assessment); date of the last annual BSP review; date of the last annual PSP review 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 diagnosed with tardive dyskinesia, including the name of the physician who is monitoring this condition, and the date and result of the most recent monitoring scale utilized o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o Documentation of in-service training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examination for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations

	o A separate list of individuals being prescribed each of the following: anti-epileptic medication being used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; trazadone; beta blockers being used as a psychotropic medication; clozaril/Clozapine; mellaril; reglan o List of new facility admissions for the previous six months and whether a REISS screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who have had a REISS screen completed in the previous 12 months. o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: individual Information Sheet; Consent Section for psychotropic medication; personal Support Plan, and PSP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations 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, including any information that is routinely collected concerning the Psychiatrists' attendance at the PST, PSP, PSPA, and BSP meetings. o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o A list of all psychiatrists including board status; with indication who has been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy,

	including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o For the last 10 <u>newly prescribed</u> psychotropic medications, Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger who are receiving psychotropic medication. o Name of every individual assigned to psychiatry clinic who has had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Ten comprehensive psychiatric evaluations per Appendix B performed in the previous six months o Documentation of psychiatry attendance at PSP, PSPA, BSP, or PST meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months <u>Documents Requested Onsite:</u> o All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 7/11/11 regarding Individual #104, Individual #80, Individual 110 and Individual #108 o All data presented, doctor's orders, and Dr. Chavez-Rice's documentation for psychiatry clinic 7/12/11 regarding Individual #72 and Individual #82 o Section J presentation book o Written description of the pilot program (regarding improvement in active treatment) o MOSES and DISCUS results for the previous six months regarding Individual #46, Individual #71, and Individual #3 o These documents: • Identifying data sheet • Annual Medical Summary and Physical Exam • Hospital section • X-ray/Lab section (for the last six months) • Psychiatry section (for the last six months) • MOSES/DISCUS (for the last six months) • Pharmacy section (for the last six months) • Consult section (for the last six months) • Physicians orders (for the last six months) • Integrated progress notes (for the last six months) • Consent section (for psychotropic medications) • PSP and PSP addendums/reviews/annual (for the past six months) • Behavioral Support Plan • For the following individuals: o Individual #161, Individual #13, Individual #56, Individual #59, Individual #8,

	Individual #16, Individual #109, Individual #69, Individual #74, Individual #191, Individual #31, Individual #32, Individual #37, Individual #81, Individual #83, Individual #126 Interviews and Meetings Held: o Eugenio Chavez-Rice M.D. facility lead psychiatrist o Mary Ann Clark, R.N., Chief Nursing Executive and Nursing Operation Officer o Ascension Mena, M.D., Medical Director o Amista Salcido, Pharm.D., Pharmacy Director with Giovanna Villegran, Pharm.D. o Valerie Grigg, M.A., BCBA, Director of Behavioral Services o Howard Pray, D.D.S., facility dentist, with Russell Riddell, D.D.S., Dental Coordinator, Raquel Rodriguez, RDH, and Jennifer Pacheco, RDH o Nohemi Ostos, C.P.T. with Kathleen Torres, L.V.N. Observations Conducted: o Observation of three psychiatry clinics including the following individuals: • Individual #104, Individual #80, Individual 110 and Individual #108, Individual #72 and Individual #82 o Observation of PSPA meeting for Individual #13 o Observation of pre-admission meeting o Observation of individuals in day therapy services
	Facility Self-Assessment: EPSSLC submitted its self-assessment, the Plan of Improvement on 7/1/11. In addition, during the onsite review, the monitor reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the lead psychiatrist wrote a sentence or two about what tasks were completed and/or the status of each provision item. The monitoring team's review was based on observation, staff interview, and document review. The facility will need to engage in similar activities in order to conduct an adequate self-assessment. The lead psychiatrist self-rated the facility as being in compliance with three provision items J1, J3, and J11. The monitoring team agreed with one of these self-ratings regarding provision J1. In discussions with the facility lead psychiatrist, the need for improved integration was noted. Some provision items in this section rely on collaboration with other disciplines. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not

	address all of the recommendations of the monitoring team). Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, all taken from this monitoring report, are set out en banc as a system. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. In several provision items (e.g., J15, J12, J4) the facility was approaching substantial compliance. In other areas, improvement was apparent, however, additional systems must be developed. The facility will benefit from the eventual development of a self-monitoring tool or a peer review process for this provision of the Settlement Agreement.
	Summary of Monitor's Assessment: Psychiatry services at EPSSLC made continued progress towards substantial compliance. Nevertheless, the facility 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 seen continued improvement with designated space provided for clinic, and administrative assistance in the form of a licensed vocational nurse and a rehab technician. These improvements had allowed for changes in the culture and process of psychiatry clinic. The clinic was more organized in that the psychiatrist received clinical information during clinic, more staff were in attendance at clinic, and discussions regarding the individuals were more detailed. While this was positive, documentation issues remained and will be discussed throughout this section of the report. 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 physician was not provided appropriate data in order to make decisions regarding pharmacology in an objective manner, and per a review of records, made medication additions or adjustments in absence of data regarding specific target symptoms. 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. Nevertheless, there were several areas where the facility was close to achieving substantial compliance ratings (e.g., J15, J12, J4), however, in other areas, while isolated improvements were seen, the facility staff must create a system for the provision of psychiatric services. Approaching this section as an isolated task list will not achieve the desired results, instead, a comprehensive, collaborative, integrated psychiatric service is required.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The current full time psychiatrist providing services at the facility, who had been designated as the lead 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 was rated as being in substantial compliance. The 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. At the time of this monitoring report, he had approximately seven additional months of experience, having started his current job 11/1/10. 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, psychiatry services suffered from: • lack of clinical resources • absence of appropriate data for the physician • need for integration of psychiatry into the overall facility treatment program • physician documentation issues.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	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 completed three comprehensive psychiatric assessments per Appendix B. For a discussion regarding this documentation please see J6 below. 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, 113 of the 131 individuals received psychotropic medications at the time of	Noncompliance

#	Provision	Assessment of Status	Compliance
		this onsite review. A review of 16 records revealed varying quality of the documentation in the quarterly medication reviews. 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 examples from this review of 16 records: <u>Individual #37</u> • The most recent monthly medication review was dated 5/10/11. In the prior contact dated 4/25/11, the psychiatrist had documented a diagnosis of malingering, stating, "was calm throughout the interview…appeared bored…continues to have minimal insight and to manipulate the staff and gets away with it every time…states he no longer wants to kill himself…no overt depression, mania or psychosis…at PST it was agreed that …behavior stems from his poor self esteem that requires constant attention and which is never fulfilled…thrives on creating chaos with staff creating a sense of pride…to compensate for his inner insecurity…has been on multiple psychotropic medications for the longest time without any major improvement…has been off medications for several months now." o The above documentation did not correspond with DSM-IV-TR criteria for a diagnosis of malingering, which requires "the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives, such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs." • This individual returned to psychiatry clinic 5/10/11 where it was documented, "has continued easily agitation, roaming all over the center, becoming assaultive and destructive…trying to get attention at all costs. Staff states…mood changes characterized by episodes of agitation and episodes of quiescence so will continue assessing the clinical picture…staff states that patient does seem to have mood changes going from agitated, hyperactive and at times dysphoric, to quiet, somber for hours at a time…will contemplate possibility of diagnosis mood disorder, not otherwise specified…we will start on Saphris and Seroquel which reportedly had not been tried in the past and has not responded with Seroquel alone." o In this second note, the psychiatrist did a good job of describing the diagnostic criteria required for a diagnosis of mood disorder, not otherwise specified. What was lacking in this document was a better description of the indication for the medication and for starting two medications in combination.	

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		Individual #32 • A copy of this individuals record revealed a notation "no psychiatry notes in last six months." This individual was prescribed psychotropic medications, including Lamotrigine, Amantadine, Trazodone, Clonidine, Chlorpromazine, Lorazepam, and Paroxetine. A review of the document request regarding the frequency of clinical contact for each individual revealed that this individual was seen in psychiatry clinic 3/14/11 and 5/27/11, however, documentation was not located. Individual #69 • The last quarterly medication review was dated 6/14/11. This document was reviewed. There was no comprehensive psychiatric assessment located in the individual record. Per the 6/14/11 document, "Current DSM-IV psychiatric diagnoses: Oppositional Defiant Disorder; Impulse Control Disorder; ADHD combined; Psychotic disorder, not otherwise specified…medications: Seroquel XR…Adderall XR…Guanfacine…staff states that patient appears to have decompensated and has been continuously aggressive and agitated…refuses his meds…very agitated the next morning…therefore sedated with Seroquel. Staff doesn't report any psychosis, mania or depression…PST agreed that patient suffers from ADHD, Impulse Control Disorder…Oppositional Defiant Disorder…coupled with an intractable seizure disorder…has had a good response to Adderall XR and Seroquel…this is the least restrictive treatment that has helped patients behavior…" o This documentation did not discuss specific diagnostic criteria for the diagnosis, nor did it justify diagnoses prior to the prescribing of psychotropic medication. As illustrated by the examples above, the case formulations reviewed for this monitoring report were either nonexistent, 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. 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.	

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		For further discussion regarding diagnostic practices see the discussion below in sections J6 and J10.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Per this provision 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 care. Also, as noted in J9 below, PBSP documents reviewed for this monitoring period did not adequately identify non-pharmacological interventions. 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. Although the facility POI self-rated this item in substantial compliance, following discussion with facility staff, it was understood that due to the paucity of non-pharmacological interventions, this provision would remain in noncompliance. 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 psychotropic medications</u> During the onsite monitoring review and per the record review, it appeared that the facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had remained stable at one or two incidents per month. There were a total of 10 incidents involving seven different individuals in the previous six months.	Noncompliance

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		Per the information received regarding these incidents, there were no available notations from psychiatry regarding these events because "psychiatry does not document notes regarding chemical restraints." • A review of the record of Individual #31 revealed that there were no PSP addendums documented in the previous six months. This individual received a chemical restraint 6/8/11. • A review of the record of Individual #126 revealed that this individual received a chemical restraint on 1/17/11. A PSP addendum regarding the incident was located in the record. Per this document, additional interventions included additional medication (Gabatril) with an upward titration of this medication to address impulsiveness, see the psychiatrist 1/21/11 and would receive enhanced supervision (one-to-one, 24/7). Per the psychiatric progress note dated 1/20/11 "seen and examined with PST…due to agitation and extreme restlessness for the past five days…has decompensated…(full moon) and who had not been started on medication change until this am…we expect that patients behavior will improve about 8-10 hours after she starts new medications." The new medications were not noted on the integrated progress note, however, a review of the physician's orders revealed an order dated 1/18/11 where Clonazepam 2 mg twice daily and Trileptal 300 mg twice daily in increasing titration were ordered. A notation from the clinical pharmacist later that day requested a hold on these medications due to a possible drug interaction in this individual with a history of hyponatremia with Trileptal. On 1/20/11 a physician's order discontinuing Trileptal was noted with a confirmation to start treatment with Clonazepam. A subsequent integrated progress note authored by psychiatry dated 1/28/11 revealed "reportedly is doing better…even better than when we tapered of Seroquel Lithium…this is the least restrictive Rx expect improved behavior within 30 days." There were no subsequent psychiatric progress notes in the documentation received for off-site review. • Documentation in the record of Individual #161 revealed that she received chemical restraints 4/28/11 and 5/11/11. With regard to the incident 4/28/11, a PSP addendum was included which reviewed the incident and documented good response to the chemical intervention. There was no noted non-pharmacological intervention planned or documented. A physician's progress note regarding this incident was located dated 4/29/11. This note reviewed the incident and other than the administered chemical restraint, did not document any planned pharmacological interventions. Further documentation from psychiatry included a monthly medication review dated 4/29/11, but this document did not discuss the administration of the chemical restraint.	

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		While there was mention of the emergency use of psychoactive medication documented in the DADS policy and procedure entitled "Prescribing of Psychoactive Medication" effective 5/23/07, the policy did not define time periods, nor did it define where in the record documentation should be placed. This likely contributed to the variability in the documentation of the three episodes noted above, and indicated that this was an area that would likely benefit from the development of a facility specific policy and procedure. Following this, 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 pretreatment 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 pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Per interviews with dental clinic staff and the statewide Dental Coordinator, the facility had implemented a new multidisciplinary review process for pretreatment sedation. This was accomplished via a monthly meeting including representation from dentistry, primary care, psychiatry, pharmacy, nursing, and psychology. During this monitoring visit, this multidisciplinary review was observed. Staff in attendance reviewed each individual's medication regimen. The clinical pharmacist had done due diligence in reviewing the medication interactions and potential interactions of pretreatment sedation agents with concurrently prescribed medication and articulately discussed those with the team members. Then the team rendered a decision regarding the use of pretreatment sedation and all signed off on a document indicating their approval. Per the document review, there was documentation provided of three meetings of this body (inclusive of the one attended during the monitoring visit). Per document review and staff interview, this process has not been formalized in policy and procedure. Reportedly a draft was presented to DADS in October 2010 and was awaiting approval. Per the observed meeting, 10 individual cases were reviewed regarding administration of pretreatment sedation. Of these, reportedly none had a currently implemented desensitization plan. Additional documentation provided via the document request revealed that since 12/1/10, 29 individuals had received pretreatment sedation. Of these, six were sedated at a location outside of the facility, and three were sedated for a medical procedure. Of the remaining 20 individuals, the most common pretreatment sedation agent was Lorazepam. Of these 20 individuals, six were documented as having a desensitization plan, but for all, the plan was not yet implemented. These six individuals were part of a group of 20 individuals who were reported to have medical (1) or dental (19) desensitization plans. All dental desensitization plans were noted, "in process of being in serviced." A sample of medical and dental desensitization plans was requested. No desensitization	Noncompliance

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		plans were available for medical and five plans were provided for dental desensitization. These five plans for Individual #18, Individual #65, Individual #92, Individual #11, and Individual #27 were identical with respect to interventions and were not individualized to meet the specific needs of each person. In an effort to move the desensitization process forward, dental clinic staff developed a desensitization assessment and assessed 37 individuals with respect to their progress and needs regarding desensitization. This information could be incorporated into the desensitization plans for individuals in an attempt to individualize the plans according to the individual's need/level of skill acquisition. The facility has made strides with respect to the interdisciplinary review of pretreatment sedation medications. Further effort must be made with respect to desensitization programs that target both dental and medical procedures; that are individualized and denote the specific skills an individual needs to develop, along with specific reinforcers that would be useful for each individual.	
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 12/31/10, 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. In the intervening period since the previous monitoring review, two support staff members had been recruited for psychiatry clinic. A rehab therapy technician was hired in February 2011. And a licensed vocational nurse had begun work as a support staff for psychiatry clinic five days prior to this monitoring review There were a total of 113 individuals assigned to psychiatry clinic for medication	Noncompliance

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		management. This number was derived via a count of all pharmacy medication protocols provided in response to the request for a listing of individuals prescribed psychotropic medication. This number differed from the estimation of the psychiatrist regarding the number of individuals assigned to clinic (96), the number of individuals per psychiatry clinic who are pending a comprehensive evaluation (77 plus three completed assessments for a total of 80), and the spreadsheet entitled psychoactive medication list provided by the pharmacy for May 2011 (115). For the purpose of this discussion and through the remainder of this monitoring report, the total number of 113 will be utilized. This equated to 37 quarterly medication reviews per month. Additionally, the physician would need to perform 113 comprehensive assessments annually (9.4 per month), 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. Allowing 90 minutes for a quarterly medication review and three hours for a comprehensive annual assessment, 83.7 hours of clinical consultation time per month would be consumed prior to the psychiatrist's participation in any other required activity. This indicated that 19.9 hours of physician time per week (or 0.5 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 appears to be necessary at this facility.	
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.	The overarching DADS statewide policy regarding Psychiatric Services dated 2/16/11 guided 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, and in the ensuing provisions and attached discussions there are multiple areas where additional policy and procedure could be beneficial. Per a request for examples of psychiatric evaluations performed according to Appendix B, documentation of three completed evaluations was provided. Per the psychiatry clinic "monitoring form" provided per the document request, 77 individuals participating in psychiatry clinic were scheduled for a comprehensive psychiatric evaluation, with the last individual scheduled 4/2/12. As per the information provided indicating that 113	Noncompliance

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		individuals were receiving treatment via psychiatry clinic, it seemed that there would be an additional 36 individuals to schedule. Thus, three of 113 individuals receiving care via psychiatry clinic had completed Appendix B evaluations, that is, 2.6% of the evaluations had been done. Given the minimal progress toward the completion of comprehensive assessments and the need for improvement in the assessments as noted in the examples below, this provision will remain in noncompliance. The three completed Appendix B evaluations were provided for review. While they followed the format for the Appendix B outline, there were notable deficiencies. • The 5/31/11 evaluation of Individual #73 did not include documentation regarding the bio-psycho-social-spiritual formulation, nor were treatment recommendations included. Other challenges noted with this evaluation included the lack of documented diagnostic criteria for the diagnosis of Schizoaffective Disorder, depressed and Impulse Control Disorder. In the history of present illness, a diagnosis of Posttraumatic Stress Disorder was mentioned, however, a diagnosis was not given, nor were the diagnostic criteria for PTSD reviewed. • The comprehensive psychiatric evaluation of Individual #8 dated 5/5/11 did not include the psychiatrist's signature. Also, a history of seizure disorder was noted in the history of present illness, but not noted in the medical history section of the document. Although this individual was admitted to the facility in 1998, his social history was documented as unknown. It was understandable that history prior to admission may be unknown, however, information for the period since admission would be available for inclusion. The bio-psycho-social-spiritual section of the document was blank. A review of the integrated treatment plan section revealed information from all disciplines with the exception of psychiatry. o There was a document included in the assessment that detailed psychotropic medications used for this individual. This document was useful in that it noted time periods and dosages of a particular medication. It would have been even better had it included the individual's response to a particular medication and the reason for increase/taper of an agent. o Information regarding pharmacological interventions was included in the section entitled treatment recommendations. In this section, the psychiatrist authored a good rationale for the individual's challenging behavior as well as a good documentation of the justification for the current psychotropic medication regimen.	

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		The body of the document, however, included multiple references to the fact that this individual had received little or minimal benefit from treatment with psychotropic medications leading one to consider that non-pharmacological interventions would be the mainstay of treatment for this individual. The non-pharmacological intervention section of the document needed improvement; it stated, "presently it is very little that can be done as behavioral intervention, but patient has been redirected when SIB, given a shower to calm down taken out to pick up trash which he likes to do." o Given this documentation, it was apparent that this case would have been ripe for a collaborative case conceptualization and a truly integrated treatment plan. While this document listed treatment options from various disciplines (an improvement) the next step was integration. • In the comprehensive psychiatric evaluation for Individual #13 there was documentation of previous diagnoses of Attention Deficit Hyperactivity Disorder, Impulse Control Disorder, Schizoaffective Disorder, and Depression. These diagnoses, with the exception of Impulse Control Disorder, were not included in the final diagnostic impressions, however, there was no diagnostic formulation/case conceptualization that provided the reader with a review of the required symptoms and their presence or absence in order to justify the diagnosis. This was further complicated by a review of medications prescribed for this individual (Clonazepam, Haloperidol, Adderall XR, and Lithium) with indications including Attention Deficit Hyperactivity Disorder. o The treatment recommendations were incomplete stating, "continue placement…continue behavior support plan addressing refusal, aggression and disruptive behavior, continue psychiatric consultations and monitor psychoactive medications." As in the previous example, it was apparent that this case would have been ripe for a collaborative case conceptualization and a truly integrated treatment plan.	
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,	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 not had any new admissions during the intervening period since the last monitoring review. Per documentation reviewed of a listing of individuals residing at the facility who were not currently receiving treatment via psychiatry clinic there were 49 individuals who would be appropriate for Reiss screening. Of these, 27 individuals had documented completed screens. Of the 27 individuals who had completed Reiss screening, two individuals (Individual #1 and Individual #189) were referred to psychiatry clinic. Both	Noncompliance

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	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.	of these screens were performed 5/2/11. Per a review of the Reiss screen documents for the two individual's noted above, both were signed off by the facility psychiatrist on 5/2/11 with a notation to refer them to psychiatry clinic. Additional documentation provided via the requested record review revealed that both individuals were scheduled for psychiatry clinic on 7/20/11. This amount of time between referral and scheduled clinic dates (56 working days) was excessive. A review documents provided did not reveal a facility based policy and procedure regarding referral or scheduling of psychiatry clinic. DADS policy and procedure reviewed entitled "Psychiatry Services" dated 2/16/11 did not address this issue either. The lack of a referral process likely contributed to the delay in referral. The Director of Behavioral Services was aware of the remaining 22 individuals in need of Reiss screening as well as the need for the development of a protocol for screening of individuals who had experienced a change in status.	
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. There was little improvement with regard to this provision in the intervening period since the last monitoring review. Therefore, this provision item remained 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 by psychology 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. In one instance observed during this monitoring review, psychiatry clinic staff were able to access the individual's current data sheets for review. While this showed initiative on the part of psychiatry clinic staff, the raw data was not as useful for psychiatric decision making. 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. Interviews with staff performed during this monitoring review revealed that combined case assessments and formulations were not occurring at this time. There were beginnings of integration between psychiatry and psychology, specifically the reported attempts by psychiatry to attend some PSP meetings, and there were also opportunities for interaction during psychiatry clinic; these were observed during four 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 30 minute) observations and interactions with the individuals as well as the review of information provided during the time of the clinic. In the four clinic observations performed during this onsite review, the psychiatrist met with the individual (other than one individual who declined to attend, and another who chose to visit family during scheduled clinic time) 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 more in-depth approach to psychiatric clinic was good to see and was an improvement from the time of the previous onsite review.	

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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 psychiatric resources 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, and that the required elements are included in the document. A review of the 10 most recent BSP documents provided by EPSSLC revealed no documentation of psychiatric involvement in the development of the document, nor was there a line for the psychiatrist to sign following a review or following giving input. Unfortunately, as discussed in provision item J13 below, due to clinical resource needs, psychiatry was not regularly attending PSP meetings for individuals receiving care in psychiatry clinic. Documentation revealed attendance in eight out of 45 meetings between the dates of 1/5/11 and 6/6/11. 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. During psychiatric clinics observed during this monitoring visit, the psychiatrist was frustrated with both the lack of available data, the delay of receipt of data, and the paucity of non-pharmacological interventions provided to the individuals. The monitoring team requested BSPs for the last 10 individuals prescribed psychotropic medications, but only five were provided. Across these five, only minimal non-pharmacological interventions were included. • For example, Individual #12 was diagnosed with depression, recurrent, moderate, and anxiety disorder, not otherwise specified. Her target behaviors for treatment with medication include self-injurious behavior, dysphoric mood, and anxiety/tension/sleep. These target symptoms, with the exception of self-injury, were not specifically defined in the plan, nor were they being monitored or graphed. The replacement behavior identified for self-injury was "manipulating objects" which was defined as "holding, manipulating, and using items in the environment." Other interventions were not documented. The other four PBSP documents had similar problems. This lack of non-pharmacological intervention and the psychiatrist's frustration with regard to this was observed directly	Noncompliance

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		during psychiatry clinic. Individual #110 presented to clinic and the individual's assigned psychology staff was noted to ask about the individual's level of communication as though psychology was not aware of the individual's abilities. This individual was nonverbal, yet bright, pleasant, and interactive with team members. She would likely benefit from a communication evaluation and augmentative communication, however, this was not currently being provided. Additionally, staff indicated that this individual engaged in some self-stimulatory behavior (crumpling paper appearing to enjoy the noise). This individual was not currently participating in sensory activities, and could be referred for these as well. In other words, psychology, speech and language, and OT/PT non-pharmacological treatments appeared to be relevant to her overall treatment plan. Similar deficits in non-pharmacological interventions were noted during clinic for Individual #72 and Individual #82. In clinic observations, the psychiatrist was 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 was 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, both pharmacological and non-pharmacological.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	DADS policy and procedure entitled "Psychiatry Services" dated 2/16/11 required the development of a risk benefit analysis by psychiatry. Per staff interview and record review, there had been no change in practice with regard to this provision in the intervening period since the previous monitoring review. A current review of the records of 16 individuals at the facility who were prescribed various 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 authored by psychology staff, however, these did not satisfy the requirements of this provision item. As expected, they remained 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). Staff interviewed agreed that documentation of this information in the BSP by non-prescribing professionals was not appropriate. Further, t risk/benefit/alternatives to medication were being authored and presented to	Noncompliance

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		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, 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 symptoms be 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. Given the improvement in staff attendance at psychiatry clinic, as well as the increased amount of time allotted for each clinical consultation, the development of the risk/benefit analysis could be undertaken in a collaborative approach during psychiatry clinic. This documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that	The facility had in place a review system for polypharmacy that was centered in the pharmacy department. As of November 2010, the facility had instituted a monthly polypharmacy committee meeting. Documentation of minutes from this monthly meeting reviewed that overall, • The total number of individuals residing at the facility prescribed antipsychotic medication had decreased from 60 in October 2010 to 50 in June 2011. • The total number of individuals who met criteria for antipsychotic polypharmacy had decreased from eight in October 2010 to six in June of 2011. • The average number of "psychoactive" medications utilized had been reduced from 3.66 in October 2010 to 3.31 in June of 2011. A review of the active psychoactive medication list by drug class revealed that there were four individuals classified as meeting criteria for intraclass polypharmacy who were	Noncompliance

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	the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	currently in the process of a medication taper of an agent in the polypharmacy class. A review of the pharmacy quarterly drug regimen documents located in 16 individual active records revealed timely reviews in all records. The reviews were comprehensive and offered appropriate guidance and recommendations to the psychiatrist. In all of these cases, the treating psychiatrist signed the review. Observation of the interaction between the psychiatrist and the clinical pharmacist during psychiatry clinic during this onsite review revealed good communication and exchange of information and ideas. Per a review of the active psychoactive medication list by drug class provided by the facility pharmacy, there were a total of 70 individuals who met criteria for polypharmacy. There were 50 individuals prescribed antipsychotic medications at the facility (a decrease from 61 individuals the previous monitoring review). Of these: • Five individuals were prescribed two antipsychotics (reduced from 6 during the previous monitoring review) • One was prescribed three antipsychotics (reduced from two during the previous monitoring review. The one individual who remained on three antipsychotic medications had documented attempts at medication tapers resulting in "decompensation.") Regarding other classes of medication: • A total of 35 individuals were prescribed antidepressant medications (a decrease from 47 during the previous monitoring review): o Of these, three were prescribed two antidepressant medications (a decrease from six in the last monitoring period). • There were 57 individuals prescribed anxiolytic medications (a decrease from 60 in the previous monitoring period). o Of these, three were prescribed two anxiolytic medications (an increase from two in the previous monitoring period). • Five individuals were prescribed stimulant medication (a decrease from 10 during the previous monitoring period). o There was no polypharmacy noted in this class. • Fifteen individuals were prescribed sedative medication (an increase from 10 during the previous monitoring period) o There was one individual prescribed two sedative medications (an increase from one during the previous monitoring period). Of the total of 116 individuals prescribed psychotropic medication from any class in the month of June 2011: • A total of 61 individuals were prescribed two or more psychotropic medications	

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		from the same class. The majority of these individuals (50) were prescribed two or more antiepileptic medications. In 12 of these cases, the medication was being used in the absence of a seizure disorder. Therefore, the majority were receiving two or more antiepileptic medications as a result of a diagnosis of seizure. It is hoped that the recent increase of neurological clinical resources will allow for determination of the need for polypharmacy with regard to antiepileptic medications. As was discussed during the onsite review, in some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must, however, justify the clinical hypothesis guiding said treatment. For example, the documentation regarding polypharmacy in the record of Individual #83 (treated with three antipsychotic medications) dated 4/25/11 stated: "Patient seems to be responding to polypharmacy Rx for mania which is the only way patient has been able to compensate and we will reassess periodically for the need of polypharmacy." Additional information would be necessary in order to adequately justify the use of polypharmacy for this individual. The facility made strides with regard to this provision, however, given the lack of specific documentation regarding the rationale for polypharmacy in the individual records where polypharmacy was present, this provision will be rated as being in noncompliance.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The review of a sample of 16 records revealed documentation that the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) was being performed by the Nurse Case Manager when indicated. The documents reviewed in the individual records included a completed section titled "prescriber review" or "evaluation" depending on the instrument, and were signed and dated by the psychiatrist. This was an improvement over past monitoring visits. A review of psychiatric documentation (specifically quarterly medication reviews) revealed that in approximately 25% of the documentation reviewed, MOSES and DISCUS results were included in the documentation and reviewed as part of the clinical decision making process. It is pertinent to note that the documentation, where it was included, was more recent documentation. During psychiatry clinics observed during this monitoring review, the psychiatrist was presented with MOSES and DISCUS examinations (among other data) for review. The above were all improvements over prior monitoring visits. The facility nursing case management staff developed a tracking system for scheduling/completion of both MOSES and DISCUS examinations. These were provided	Noncompliance

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		for review, and revealed that, in general, examinations were documented as completed. Some nursing staff have had in-service training regarding MOSES and DISCUS examinations. Documentation provided revealed that the most recent training occurred in 2010 where four staff members attended. Documentation revealed that currently, there were 14 nursing staff pending instruction (four of these were identified as nursing case managers). There was note of a "tentative training date for DISCUS…week of July 30, 2011. Tentative training date for MOSES training pending." Given the need for completion of nursing in-service training and the need for the demonstration of consistency over time with regard to documentation of the use of this information in clinical decision making, this provision will be rated in noncompliance.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	A review of the records of 16 individuals did not reveal any specific treatment plans for psychotropic medication. Per an interview with the facility psychiatrist, there were no specific treatment plans regarding treatment with psychotropic medications. A noncompliance rating had been assigned, as was the facility's self-rating in the POI. Documentation provided in response to the monitoring team's request: "For the last 10 newly prescribed psychotropic medications, provide psychiatric treatment review/progress notes documenting the rationale for choosing that medication" was reviewed. In response, the psychiatrist provided documentation regarding the current diagnosis and the behavioral/pharmacological treatment hypothesis. Other required elements (the expected timeline for the therapeutic effects of the medication to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were included only sporadically across these documents. The facility did not have a facility based policy and procedure governing psychiatric treatment. Individuals were seen in psychiatry clinic quarterly, or more frequently as needed. During the monitoring review, four psychiatry clinics (for a total of six individuals) were observed. In all but two instances, the individual was present for clinic (Individual #108 was scheduled for clinic, but had the opportunity to visit family during this time and Individual #104 refused to attend). All treatment team disciplines were represented during each clinical encounter. The team did not rush clinic, often spending more than 40 minutes with the individual and discussing the individual's treatment. During these clinics, the psychiatrist made attempts to review behavioral data. In all cases, the data were not up to date, and in the majority of cases, data were not appropriately graphed. This made data based decision making impossible for the psychiatrist.	Noncompliance

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		For example, in the case of Individual #104, although available data were graphed, the last available data were 5/11/11 (clinic occurred 7/11/11). Staff presented anecdotal instances of increased behavioral challenges, and concern that increased behaviors could be the result of constipation or poor sleep. Various staff members (e.g., nursing, direct care) reported symptoms differently; nursing was unable to produce information regarding bowel history, and psychology was unable to provide information regarding sleep data. Given the divergent anecdotal information, the psychiatrist requested that staff members gather the appropriate data for review at a later date. • Upon review of the documentation provided to the psychiatrist as well as documentation generated by the psychiatrist as a result of this clinical encounter, laboratory examinations dated 7/6/11 were not noted in the psychiatrist's note. These results revealed an ammonia level of 58 (11-35). Elevations of ammonia can cause increased agitation and confusion (among other effects). This may have been an etiology of this individuals increased behavioral challenges, however, in the absence of the individual's full record, it was impossible to determine if this was a new event, or a long-standing elevation. A review of plans to evaluate the elevated ammonia level were noted in the "Neuro-Psych" clinic documentation 6/28/11. In another clinical consultation regarding Individual #110, data were not graphed, and psychology staff attempted to correlate behavioral and menses data during clinic. Additionally, although clinic occurred on 7/11/11, the last available data graphed were dated 5/20/11. In all cases, PST members in attendance engaged in a discussion regarding the behavioral/pharmacological hypothesis. In most cases, the psychiatrist did a good job verbalizing the rationale for the prescription of medication and for the biological reason(s) that an individual could be experiencing difficulties and how a specific medication could address said difficulties. The team then assigned percentages to the effect of interventions of pharmacotherapy versus behavioral therapy. The assignment of percentages was arbitrary and, in all cases, did not adequately reflect the discussion that the PST team, including the psychiatrist, engaged in prior to the assignment of these percentages. The monitoring team discussed with the psychiatrist that it would benefit the PST to simply document the discussion and avoid the assignment of percentages. At the time of the onsite monitoring review, the facility psychiatrist reported that he was participating in the PSP process, as he was able. Although the overview of the psychiatrist's weekly schedule revealed that 14 hours per week were designated for PST, PSP, and PNM meetings, a review of requested data regarding the psychiatrist's	

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		participation in PSP meetings revealed attendance in three out of 45 meetings between the dates of 1/5/11 and 6/6/11. Attendance was documented via a signed attendance sheet on 1/5/11 regarding Individual #13, 2/15/11 regarding Individual #104, and on 3/21/11 regarding Individual #37. Interviews with psychiatry clinic personnel (psychiatric technician and licensed vocational nurse) revealed that these staff members were attending PSP meetings in the psychiatrist's stead. A review of the documentation, however, did not reveal their signatures in the section designated for psychiatry. 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. A review of documentation did not reveal any collaborative case conceptualizations or diagnostic formulations. In an effort to improve coordination between psychiatry and psychology, bi-weekly meetings had been established between these two departments for the reported purpose of discussions regarding justification of diagnosis, specific target symptoms for monitoring, and response to treatment with psychotropic medications. Per review of the minutes, it was apparent that over time, increased communication was starting. In the last set of minutes, discussion of issues such as collecting data to determine root cause analysis for aggression, and how to streamline data collection efforts were documented. 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.	
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	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 previous monitoring reviews. These remained in effect at the time of this monitoring review. Per an interview with the facility psychiatrist, the process for informed consent remained the same as in prior monitoring reviews, where as indicated in the facility POI, "a process is in place for obtaining informed consent by the nurse case manager. A consent form is	Noncompliance

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	consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	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 records available for review revealed that these forms were either a signed document that included the medication, dosage, justification, and plan, and notation regarding family notification, or a signed checklist to ensure that specific information was addressed via the informed consent process. Documentation of 25 consents for psychotropic medication for nine individuals was reviewed (Individual #77, Individual #39, Individual #32, Individual #68, Individual #12, Individual #108, Individual #81, Individual #161 and Individual #51). These forms named the specific medication/dosage and an indication for the medication, however, there was no documentation of the side effects or the risk/benefit analysis for the use of a particular medication. These documents included the name of the "person giving explanation" which was, in all cases, the nurse case manager. The signature of the person giving consent was illegible in 13 of the 25 examples. This current facility practice was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or guardian) 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 record. Given the importance of informed consent, the development of a facility policy and procedure regarding this topic should be considered. Further, the facility should 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 and the facility medical director, there had been efforts to coordinate care with neurology. This was an area of continued progress. Previously, the neurologist was available one half day per month. Currently, both interview and document review revealed that neurology clinic was scheduled one half day (four hours) weekly. The last week of the month was designated as "Neuro-Psych" clinic. At the time of this review, one "Neuro-Psych" clinic had been completed on 6/29/11. Documentation reviewed regarding this clinical encounter revealed that four individuals (Individual #104, Individual #8, Individual #61, and Individual #100) were seen.	Noncompliance

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		Consultation with psychiatry was documented in the neurology notes for each individual. Written consultations per neurology appeared thorough. There was also psychiatric documentation of the clinical encounters provided for review. This documentation was not in the form of physician's progress notes, but rather a listing of each individual discussed and the psychiatrist's impressions. While this documentation was helpful, and would assist the psychiatrist in "Neuro-Psych" clinic, including the specific information regarding each individual in the individual's record should be considered. A listing of individuals referred to "Neuro-Psych"" clinic was provided for review. This listing included the names of 46 individuals. This listing was identical to the list of individuals participating in psychiatry clinic who had a diagnosis of seizure disorder. Given the proposed monthly "Neuro-Psych" clinic, with four individuals seen in each clinic, each individual would be seen approximately once per year in the combined clinic. As the physicians begin organizing and participating in this clinical consultation, they 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 46 individuals currently prescribed both seizure and psychotropic medications). Unfortunately, the neurologist was not available for interview during the week of this onsite review, and therefore, there was no opportunity to observe neurology clinic. While the increased neurology consultation hours and the designated "Neuro-Psych" clinic were improvements, this clinic will need to demonstrate consistency in occurrence and documentation.	

Recommendations:

1. Develop case formulations that document 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 (J2).

2. 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 (J3)

3. Continue to reduce reliance on emergency psychotropic medications by identifying non-pharmacological interventions to address individual challenges (J3).

4. Improve data collection regarding the use of emergency psychotropic medications (J3).

5. Develop facility specific policy and procedure regarding the emergency use of psychoactive medication (J3).

6. Formalize the process for the multidisciplinary review of individuals requiring pretreatment sedation via the creation of policy and procedure governing this process (J4).

7. Individualize and implement the desensitization plans for dental and medical clinic (J4).

8. Develop an accurate listing of individuals receiving services via psychiatry clinic (J5).

9. 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 (J5).

10. Complete overdue annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B (J6, J2).

11. Implement the Reiss screen for new admissions, those individuals who do not have a current psychiatric evaluation, and for those individuals who have experienced a change in status. The facility could develop policy and procedure regarding this process (J7).

12. Develop a protocol for referral of individuals to psychiatry clinic. This should include acceptable timelines for referral and completion of the psychiatric consultation (J7).

13. Ensure that the target behaviors/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate (J8).

14. Implement 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 (J8).

15. Ensure psychiatric involvement in the formulation of the BSP (J9).

16. Identify non-pharmacological interventions for individuals that are included in the BSP such that the least intrusive and most positive interventions can be utilized (J9).

17. Ensure that referrals to other disciplines for assessment and treatment are made as needed (e.g., medical, speech therapy, OT, PT) (J9).

18. Formalization of the interdisciplinary process to author and review risk/benefit analysis for the prescription of psychotropic medications to include psychiatry as the primary author, primary care and nursing. This documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. This process should be formalized via policy and procedure. (J10).

19. 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 (J11).

20. Continue to improve documentation of psychiatric review, and clinical correlation of DISCUS and MOSES examination results (J12).

21. Complete nursing in-service training regarding MOSES and DISCUS (J12).

22. Develop a facility specific policy and procedure regarding psychiatric services (J13, J7).

23. Improve psychiatric documentation to include a diagnostic formulation and justification for a specific diagnosis and treatment. This should include documentation of the behavioral/pharmacological hypothesis in a narrative format (J13, J2).

24. 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 (J13, J8).

25. Ensure that the indications for specific medications correspond to the diagnosis, and that appropriate defined behavioral data points are being monitored (J13, J8).

26. 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 (J13, J9, J8, J6).

27. Integrate psychiatry into the PSP process. This will first require that there are adequate clinical resources allowing available time for the psychiatrist to attend PSP meetings. (J13, J8).

28. Individualize the process for Informed Consent (J14).

29. Consult with DADS administration regarding a statewide policy and procedure for Informed Consent (J14).

30. Determine the adequacy of neurological consultative availability (J15).

31. Continue clinical consultation clinic for psychiatry and neurology. Documentation for both psychiatry and neurology participation should be included in the individual's medical record (J15).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Positive Behavior Support Plans (PBSPs) for: • Individual #104 (7/12/11), Individual #10 (4/29/11), Individual #52 (4/29/11), Individual #73 (6/14/11), Individual #161 (6/8/11), Individual #39 (6/22/11), Individual #37 (7/6/11), Individual #191 (4/4/11) o Annual Psychological updates for: • Individual #80 (4/11), Individual #69 (6/2/11), Individual #67 (3/14/11), Individual #107 (6/2/11), Individual #10 (2/14/11), Individual #183 (6/14/82), Individual #13 (2/22/11), Individual #161 (6/13/11), Individual #184 (5/9/11), Individual #191 (7/11/11), Individual #144 (6/14/11) o Safety Plans for: • Individual #13, Individual #39, Individual #81, Individual #109 o Progress reviews of Positive Behavior Support Plans (PBSPs) for: • Individual #104, Individual #10, Individual #52, Individual #73, Individual #161, Individual #39, Individual #37, Individual #191 o List of individuals and psychological services offered at EPSSLC, undated o A list of all psychology department staff and status of enrollment in BCBA coursework, undated o Internal Peer Review Committee Meeting Minutes dated 4/19/11, 5/3/11, 6/7/11, 6/14/11 o EPSSLC Plan of Improvement, dated 7/1/11 o Spreadsheet of all Individuals with a PBSP o Momentary time-sample data collection sheets for Individual #112, undated o Functional Analysis data for Individual #78, undated o ABC data for Individual #32 o Training guide for teaching Behavior Support Plans, undated o Training Guide for teaching Safety Plans o Competency Check for Behavior Support Plan, undated o Competency Check for Restraint Prevention and Rules, undated o Competency check for Safety Plan, undated o EPSSLC PBSP Peer review form, dated 12/28/10 o Data Collection monitoring form, undated o Weekly Psych Tech Task List, undated o Circles Counseling Plan, dated 6/15/10 for Individual #37 o Anger Management Counseling Plan, dated 7/22/10 for Individual #61 o Circles Counseling Plan, dated 9/14/10 for Individual #120 o Health Counseling Plan, dated 8/18/10 for Individual #178 o Health Counseling Plan, dated 6/11/10 for Individual #161

	o Circles Counseling Plan, dated 6/15/10 for Individual #112 o Health Counseling Plan, dated 6/11/10 for Individual #79 o Health Counseling Plan, dated 6/11/10 for Individual #39 o Circles Counseling Plan, dated 6/11/10 for Individual #39 o List of individuals (and frequency of contact) receiving counseling, undated o Copy of a blank Individual/Group Therapy Progress Note, dated 6/11/10 <u>Interviews and Meetings Held</u>: o Valerie Grigg, Director of Behavioral Services o Carmon Molina, Associate Psychologist o Marisela Franco, Associate Psychologist o Mario Rodriquez, Associate Psychologist 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; Rosina Duran, Psychology Assistant; Jaime Altamirano, Psychology Technician; Adrian Marquez, Psychology Technician <u>Observations Conducted</u>: o Data Collection Meeting: • Staff Present: - Jaime Monardes, Director; Ruben Morales, Assistant Psychologist; Victor Loya, Assistant Unit Director; Valerie Grigg, Director of Behavioral Services; Priscilla Munoz, Medical Records Coordinator; Jan Chowning Active Treatment Coordinator o Psychiatry Clinic Rounds: • Staff Present: - Eugenio Chavez-Rice, Psychiatrist; Giovanna Villagran, Clinical Pharmacist; Maria Viteta, RN; Nohemi Ostos, Psychiatric Technician; Kathleen Torres, Recreation; Elsa Mendoza, Associate Psychologist; Erika Hernandez, DCP; Aurora Ramos, QMRP • Individual Presented: Individual #72 o Psychiatry Clinic Rounds: • Staff Present: - Eugenio Chavez-Rice, Psychiatrist; Aurora Ramos, QMRP; Rosa Renteria, QMRP; Marisela Franco, Associate Psychologist; Giovanna Villagran, Clinical Pharmacist; Phillip Bueno, RN case manager; Clarisa Luna, DCP • Individual Presented: Individual #38 o Internal Peer Review Meeting: • Staff Present:

	- Valerie Grigg, Director of Behavioral Services; Carmen Molina, Associate Psychologist; Marisela Franco, Associate Psychologist; Mary Webb-Tafoya, Associate Psychologist; Mario Rodriquez, Associate Psychologist; Maya Deslongchamps, Behavior Analyst Intern • Individual Presented: - Individual #39 o Personal Support Plan addendum meeting • Staff present: - Alex Euzarraga, QMRP; Phillip Bueno, RN case manager; Marisela Franco, Associate Psychologist; Eugenio Chavez-Rice, Psychiatrist; Ronni Avita, Assistant Director of Programs; Myriam Valdez, Program Developer; Kathleen Torres, Recreation • Individual Discussed: Individual #13 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) • Implementation of behavior support plans
	Facility Self-Assessment: EPSSLC submitted its Plan of Improvement (POI), dated 7/1/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. In the comments section of each item of the provision, the Director of Psychology identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. EPSSLC's POI indicated substantial compliance for item K2, and noncompliance for the remaining items of this provision. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. 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, the monitoring team suggests that the facility establish, and focus their activities, on these short-term goals. The specific provision items that the monitoring team suggests that the facility focus on in the next six months are summarized below,

	and discussed in detail in this section of the report.
	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 continued progress in several areas. These included: • The abandonment of the practice of paging psychologists whenever a behavioral outburst occurred • All psychologists were enrolled in coursework for board certified behavior analyst (BCBA) certification (K1) • Expansion of the data collection system (K4) • The establishment of a method for collecting and tracking objective measures of data reliability (K4, K10) • The establishment of treatment integrity (K4, K11) • The continued development of goal directed psychological therapies with measurable objectives and treatment expectations (K8) • The development of a protocol for the training of the implementation of Positive Behavior Support Plans (K12) The areas that the monitoring team suggests EPSSLC focus on for the next onsite review are: • Ensure that DCS staff are trained and data are reliable (K4, K11, and K12) • Ensure that all treatment decisions are data-based (K4) • Provide support in the form of appropriate data collection and presentation of data, to foster data-based decisions for other departments (e.g., psychiatry, habilitation services)(K4) • Provide technical support to other departments (e.g., program developers, dentistry) to ensure that they correctly and effectively utilize the principles of applied behavior analysis (K1) • Ensure that the newly developed treatment integrity system is consistently used throughout the facility, that data are regularly tracked and maintained, and that minimal acceptable integrity scores are established (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	Despite improvements in the enrollment of all psychologists in coursework leading to certification in Applied Behavior Analysis, this provision item was rated as being in noncompliance because not all psychologists at EPSSLC were currently certified as applied behavior analysts. At the time of the onsite review, all five psychologists that wrote positive behavior support plans (PBSPs) were enrolled in course work toward becoming board certified behavior analysts (BCBA). Additionally, the director of psychology was certified as a behavior analyst, and was providing supervision to the psychologists enrolled in BCBA	Noncompliance

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	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.	coursework. EPSSLC and DADS are to be commended for their efforts to recruit and to train staff to meet the requirements of this provision item. The facility had developed a spreadsheet to track each psychologist's BCBA training and credentials.	
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 continued to be in substantial compliance with this item. The Director of Psychology had a master's degree, was a certified applied behavior analyst (BCBA), and had more than five years of experience working with individuals with intellectual disabilities. The supervisees that were interviewed had indicated that they had positive professional interactions with, and received professional support from, the director of psychology. Finally, under the director's leadership, the department has continued to improve their knowledge and application of applied behavior analysis, 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.	As discussed in the last report, EPSSLC had 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, this item was rated as being in noncompliance. The internal peer review meetings at EPSSLC provided an opportunity for psychologists to present cases that were not progressing as expected. The facility recently added the review of PBSPs and safety plans as part of internal peer review. During the peer review meeting observed by the monitoring team, Individual #39's safety plan was reviewed. There was active discussion and several examples of staff sharing strategies and suggestions to better identify the variables affecting Individual #39's undesired behaviors, and improve the safety plan. Review of minutes from internal peer review meetings indicated that peer review meetings were attended by the majority of psychologists in the psychology department. The minutes also indicated, however, that the peer review 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	Noncompliance

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		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). Operating procedures for both internal and external peer review committees will also 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 facility had made improvements in this area. EPSSLC had continued to expand its data system and had begun to arrange data collection reliability since the last onsite review. In order to achieve substantial compliance, however, the facility needs to track the planned data collection reliability data, demonstrate the consistent use of sensitive data systems, consistently graph data at intervals that are useful for making data-based decisions, and collect and track interobserver agreement (IOA) data. At the time of the onsite review, the facility was conducting hourly data collection (i.e., target behaviors) in 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 or neglected to record data. This system also allowed observers to determine if data were collected on an hourly basis by noting if data, or a zero, were recorded in each interval up to the time of the observation. Replacement behavior was recorded twice (i.e., first and second shift) each day. The monitoring team did their own data collection reliability in each cottage by sampling one individual data book, and noting if data were recorded up to the previous hour for target behaviors, and previous shift for replacement behaviors. The results for target behaviors were disappointing. • As found in the last report, the target behaviors for only one of eight data sheets (12%) were completed up to the previous hour. • The range of missing data was from three hours (cottage 508), to all day (cottages 506 and 513) • Most disturbing was finding one data sheet (Individual #184's in Cottage 511) where the data were already filled out until 10 pm, however, the observation was at approximately 7 pm of the same day. These observations indicated that DCPs were not consistently recording target behaviors. This was a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. It was	Noncompliance

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		encouraging that the facility recently began conducting data collection reliability sessions where psychology technicians were assigned to review completed data sheets weekly, and determine if DCPs were recording data at the intervals specified. It is now recommended that the facility establish acceptable standards of data collection compliance, and work with DCPs and their supervisors to attain those levels. The data for the replacement behavior was substantially better. • Seven of eight data sheets sampled (88%) were completely filled out (Individual #18 in cottage 513 was the lone exception). As discussed in the last report, in addition to data collection reliability (which assesses whether data are recorded), interobserver agreement data (which assesses if multiple people agree that a target or replacement behavior occurred) are critical for assessing and improving the integrity of collected data. It is recommended that the facility begin to track interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site. Additionally, specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliably collected. The facility had increased the flexibility of their data system by beginning to use Antecedent-Behavior-Consequences (ABC) data (e.g., Individual #32), momentary time-samples (e.g., Individual #112), and a functional analysis (e.g., Individual #78) to better understand and track individuals target behavior. The presentation of these data to ensure data-based treatment decisions was not, however, consistently apparent to the monitoring team. As discussed 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). The monitoring team, however, found no examples of replacement behaviors graphed. It is recommended that the facility begin to graph replacement behaviors. Although several examples of target behaviors graphed in varying increments were available and shown to the monitoring team, these graphs (and therefore opportunities for data-based decisions) were often absent at interdisciplinary meetings. For example: • In a psychiatric clinic, observed by the monitoring team, the psychiatrist wanted to evaluate the effects of a recent medication change. The data, however, were graphed in monthly increments (and only included the month previous to the medication change) and, therefore, did not allow the treatment team to objectively evaluate the effects of the medication change (see section J). • In a previous psychiatry clinic for individual #38, the psychiatrist requested that sleep data be collected to evaluate verbal reports from some team members that Individual #38 was not sleeping at night. No sleep data were available at the	

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		clinic meeting and, therefore, the psychiatrist had to make a decision about starting medication without sufficient data. • In a PSPA meeting for Individual #13, the treatment team met to evaluate his current behavioral progress. Although all team members described improvements in Individual #13's behavior, there were no data presented. In order to achieve substantial compliance with this provision item, the psychology department needs to establish and foster that all treatment decisions at EPSSLC are data-based. Specifically, they need to demonstrate the value of data by consistently graphing and presenting data in increments that allow data-based treatment decisions. Additionally, they need to ensure that the data used to make treatment decisions are reliable (see recommendations above), and they need to assist other departments (e.g., sleep data above) in the collection of reliable data presented in a form that lends itself to data-based decisions. In the absence of the psychology department assuming responsibility for the evaluation of data (and data-based decisions at the facility), some service areas will establish their own data, which may serve to confuse and overwhelm DCPs and result in unreliable data for everyone. For example: • The psychiatry department reported to the monitoring team that they were not consistently receiving the data they needed to make data-based medication decisions. Therefore, they began requesting their own data (e.g., aggression-scale data). The monitoring team observed, however, that many of the individuals that had data sheets for the aggression scale data also had data sheets for physical aggression. The result was that DCPs were required to complete two data sheets that essentially represented the same behavior. On a positive note, the facility has recently established an interdisciplinary committee to review all the data requested of the DCPs, in an effort to evaluate (and if necessary reduce) the data collection burden on DCPs at the facility. Finally, as reported in the last report, there was evidence that Positive Behavior Support Plans (PBSPs) were modified based on the absence of progress. For example: • Individual #104's PBSP indicated that his plan had been modified in April 2011 (the annual review was scheduled in July, 2011) • Individuals #73 and Individual #191's PBSPs were modified twice in the last year. Nevertheless, progress of the most severe behavior problems (i.e., physical aggression and SIB) indicated that four of eight individual's severe target behaviors were either unchanged (Individual #10 and Individual #104) and occurring at high rates (relative to	

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		levels established as objectives), or getting worse (Individual #39 and Individual #161). Clearly the lack of treatment progress in all of these individuals was not likely to be solely the result of an ineffective PBSP, however the monitoring team does expect that the progress note or PBSP would indicate that some activity (e.g., retraining of staff) had occurred if an individual was not making expected progress. Nevertheless, the monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility. The monitoring team was encouraged by these improvements in the data system at EPSSLC, and suggests that the facility focus their efforts on achieving compliance with this provision item for the next six months.	
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 initial (full) psychological assessments for each individual, and the absence of functional assessments for each individual with a PBSP. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had initial psychological assessments. No initial psychological assessments were completed since the last onsite review, therefore, none were included in this report. The initial psychological assessments reviewed in the last report were found to be incomplete. In order to attain substantial compliance with this portion of this provision item, 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 102 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 PBSP 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, and are highlighted below: • <u>All functional assessments should include both direct and indirect measures. As</u>	Noncompliance

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		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 assessments (e.g., ABC measures). If the behavior analyst is confident that indirect and direct measures have suggested clear sources of control of the targeted behavior, then the functional assessment is complete, and the results of the assessment can be used to develop the PBSP. If the results of the functional assessment remain unclear, 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. • 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 continued progress in this area. For example, as noted in K4, both ABC recording (e.g., Individual #32) and functional analysis (e.g., Individual #78) were conducted to better understand the antecedent and consequent conditions affecting an undesired behavior. The monitoring team encourages the facility to continue conducting functional assessments, and look forward to finding them documented in functional assessment reports during future onsite reviews.	
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 initial (full) psychological assessments were not complete (see K5) and, therefore, this provision item was rated as being in noncompliance. Additionally, the majority of intellectual assessments that were reported (e.g., for Individuals #161, Individual #184, Individual #191, Individual #183) were more than five years old. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to	In addition to the initial or full psychological assessment, an annual update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning.	Noncompliance

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	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.	Thus, the annual psychological assessment update should contain the elements identified in K5 and 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. Annual psychological assessments (updates) were completed for all individuals at EPSSLC. They were not, however, consistently complete. • Six of 11 (55%) of annual assessments did not contain an assessment of medical status. • None of the annual assessments reviewed included reasons why a full assessment was not needed. • None of the annual assessments reviewed noted if there were changes in adaptive functioning. • Eleven of 11 (100%) presented changes in psychopathology or behavior, and included recommendations for the upcoming year. Therefore this item was rated as noncompliance. Psychological assessments should be conducted within 30 days for newly admitted individuals. No new admissions occurred since the last review.	
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 continued improvements in this area relative to the previous review, however, some more work is needed 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. It is recommended that need for these services are documented in their annual psychological assessments, PSP, or PBSP. As noted in the last report, at the time of this onsite review, nine individuals participated in counseling/psychotherapy. 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 • Documentation reflecting evidence-based practices • Services included in progress notes	Noncompliance

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		• Qualified staff (i.e., psychologists with a degree in counseling) providing the services Since the last review EPSSLC added: • a "fail criteria" that will trigger a review and revision of interventions to ensure that services do not continue if objective are not achieved The service plans reviewed, however, did not include: • a process to generalize skills learned to living, work, leisure, and other settings It is recommended that the facility add a process to generalize skills learned for all psychological services offered.	
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 not all PBSPs reviewed contained adequate use of all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. A list of individuals with PBSPs and dates of revision indicated that 50 PBSPs were completed since the last review. Eight (16%) of these PBSPs were reviewed to evaluate compliance with this provision item. All eight of the PBSPs reviewed had the necessary consent and approvals. All of the PBSPs reviewed included descriptions of target behaviors, however, two (25%) of these were not operational. For example: • Individual #161's PBSP defined her self-injurious behavior (SIB) as "…trying to gag herself," and "…attempts to make herself vomit…" This definition required the reader to infer if Individual #161 did indeed have an intention to injure herself or to cause vomiting. An operational definition should not require DCPs to infer an individual's intentions. An operational definition should only include observable behavior. An operational definition of Individual #161's SIB would omit the intentions and simply include the self-injurious behaviors, such as putting her entire hand in her mouth, or pinching herself on her legs or arms. • Individual #191's PBSP defined spitting as "...spitting on staff or peers when he is angry or unable to attain what he wants through manipulation." On the other hand, the monitoring team was pleased to find that the majority of PBSPs reviewed (75%) contained operational definitions that were operational, clear, and complete. A typical example was: • Individual #10's physical aggression was defined as "hitting, slapping, kicking, punching, and throwing objects at others."	Noncompliance

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		All PBSPs should include operational definitions of target behaviors. All eight of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but only four of the consequences (50%) identified were clearly based on the stated function of the behavior (although functional assessments were not completed for all individuals, all the PBSPs reviewed indicated the hypothesized function of the behavior). Typical examples of interventions not related to the hypothesized function were: • Individual #39's PBSP described his physical aggression to be maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). His intervention, however, following target behaviors included "Offer (Individual #39) a change of environment… and attempt to identify the source of the situation and remove it." If his aggression was maintained by negative reinforcement, then this intervention would likely encourage, rather than discourage, his physical aggression because it allowed him to escape unpleasant activities by engaging in the target behavior. On the other hand, removing the hypothesized source of the aggression BEFORE the target behavior occurs would represent a good antecedent procedure. In fact, Individual #39's functional replacement behavior was teaching him to use alternative ways to communicate that he doesn't like something or needs a break from an undesired activity. Unfortunately, the antecedent procedures in Individual #39's PBSP did not include the encouraging and allowing Individual #39 to escape and/or avoid (whenever practical) undesired activities by using desirable forms of communication. Ideally, after the aggression occurs, Individual #39 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of the aggression is such that it is dangerous to maintain him in the activity following aggression, however, then the PBSP should specify his return to the activity when he calm, and again encourage him to escape or avoid the demand by using desired forms of communication. The point is that the PBSP should clearly state that staff should be encouraging and prompting Individual #39 to use desired forms of communication to tell us when he wants to terminate, or have a break from, an activity. Once the target behavior occurs, it may be necessary to remove the source (i.e., the undesired activity) for safety reasons. The PBSP, however, needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future aggressive behavior. • Individual #161's PBSP hypothesized that her SIB was maintained by attention. The intervention following SIB, however, included redirecting her by attempting to get her to do something new like do a puzzle with the staff. If her SIB was	

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		maintained by attention, this intervention may result in an increase in the target behavior. An alternative procedure, that would be more consistent with the hypothesized function, would be to attempt to redirect her to something, but minimize the attention until the SIB stops. Once the SIB stops, then staff would be directed to do an activity with her that requires sustained staff attention. On the other hand, seven of eight (88%) of the PBSPs reviewed included the use of antecedent interventions that appeared to be based on the hypothesized function of the target behavior. Typical examples included: • Individual #191's PBSP hypothesized that negative reinforcement was the primary function of his undesired behavior. His antecedent intervention focused on providing choices, and giving him more time to complete undesired tasks if he refuses, but does not engage in the target behaviors. • Individual #37's PBSP hypothesized that attention was the primary function of his property destruction. His antecedent intervention focused on the provision of staff attention for desired alternative behaviors, such as asking for assistance. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #73's PBSP hypothesized that her aggression functioned to gain attention. Antecedent interventions included attending to her when she initiated appropriate social interactions. Her intervention following physical aggression included attempting to change the environment, but specified that staff minimize the attention she receives following physical aggression. Finally, her PBSP specifically directed staff to ensure that Individual #73 receive more attention following desired relative to undesired behaviors. 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. Replacement behaviors were included in all eight PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified and providing that reinforcer for alternative behavior is practical. The monitoring team found that all the replacement behaviors that practically could be functional, were functional. As reported in the last review, none of the PBSPs reviewed included specific instructions	

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		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 included into the current methodology, data system (when appropriate), and schedule of implementation for other skill acquisition plans at EPSSLC. 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). Overall, four (Individual #10, Individual #27, Individual #73, and Individual #52) of the eight PBSPs reviewed (50%) represented an example of a complete plan that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represents an improvement over the last review when only 21% of the PBSPs reviewed were judged to be acceptable. The monitoring team is encouraged by this improvement in the quality of the PBSPs and looks forward to continued progress in this provision item.	
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.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite review (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for achieving substantial compliance of this provision item. Target behavior data were consistently graphed monthly at EPSSLC. At the time of the onsite review, replacement behaviors were not graphed. It is recommended that the facility begin to graph replacement behavior. As discussed in K4, 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. It is recommended that all graphs 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.	Although there were several improvements in this provision item since the last review, it was rated as being in noncompliance because, at the time of the onsite review, the facility did not demonstrate that PBSPs were reliably implemented by DCPs. The monitoring team was encouraged to learn that EPSSLC recently developed and implemented a PBSP review sheet to ensure that plans were written at a level that is understandable to DCPs. The most direct way, however, was to ensure that PBSPs were implemented as written is to establish a system to systematically monitor treatment	Noncompliance

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		integrity. EPSSLC had also recently developed a tool (and procedures) for collecting treatment integrity. At the time of onsite review there were no integrity data available for review. The monitoring team looks forward to reviewing integrity data during the next onsite review. It is recommended that the newly developed treatment integrity system be consistently used throughout the facility, that data be regularly tracked and maintained, and minimal acceptable integrity scores established.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	As reported in the last review, each psychologist at EPSSLC maintained logs documenting DCP training on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. These trainings, however, were not 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. Just prior to the onsite review, EPSSLC developed a new protocol for the training of PBSPs. In order to meet the requirements of this provision item, it is recommended that this new staff training procedure include a competency-based component. Additionally, it is recommended that the facility develop a centralized tracking system to ensure that all staff are trained in the implementation of each individual's PBSP.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	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 131 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. It is recommended that peer review meetings be scheduled and occur weekly (K3).
2. Monthly external peer review meetings should be added (K3).

3. Operating procedures for both internal and external peer review committees need to be established (K3).

4. It is recommended that the facility begin their planned data collection reliability checks, establish acceptable standards of data compliance, and work with DCPs and their supervisors to attain those levels (K4).

5. It is recommended that the facility begin to track interobserver agreement (IOA) data for all target and replacement behaviors in each home and day/vocational site. Additionally, specific data collection compliance and IOA goals should be established, and feedback and training should be provided to DCPs and their supervisors to ensure that data are reliably collected (K4)

6. The psychology department needs to demonstrate the value of data by consistently graphing and presenting data in increments that allow data-based treatment decisions. Additionally they need to ensure that the data used to make treatment decisions are reliable, and they need to assist other departments in the collection of reliable data presented in a form that lends itself to data-based decisions (K4)

7. 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 (K5)

8. All individuals with a PBSP should have a functional assessment completed (K5)

9. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K7)

10. It is recommended that the need for psychological services (other than PBSPs) are documented in annual psychological assessments, PSPs, or PBSPs (K8)

11. The facility should add a procedure to ensure that learned skills are generalized outside the clinical environment for all psychological services offered (K8)

12. All PBSPs should include operational definitions of target behaviors (K9)

13. 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 (K9)

14. All replacement behaviors should include specific skill acquisition plans for training, unless there is a reasonable rationale to not do so (K9)

15. The facility should begin to graph replacement behavior (K10)

16. Graphs should consistently contain clear demarcation of changes in medication, health status, or other relevant events (K10)

17. It is recommended that the newly developed treatment integrity system be consistently used throughout the facility, that be data regularly tracked and maintained, and minimal acceptable integrity scores established (K11)

18. It is recommended that the newly developed PBSP training protocol include a competency-based component. Additionally it is recommended that the facility develop a centralized tracking system to ensure that all staff are trained in the implementation of each individual's PBSP (K12)

The following is offered as an additional suggestion to the facility:

- 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. The monitoring team suggests that EPSSLC focus on the establishment of consistent treatment integrity (K11) the issues surrounding data collection (and reliability) discussed in K4 for the next onsite review. Specifically it is recommended that the facility focus on the following for the next six months:
    - Ensure that DCS staff are trained and data are reliable (K4, K11)
    - Ensure that all treatment decisions are data-based (K4)
    - Provide support in the form of appropriate data collection and presentation of data, to foster data-based decisions for other departments (e.g., Psychiatry, Habilitation Services, etc.)(K4)
    - Provide technical support to other departments (e.g., Program Developers, Dentistry) to ensure that they correctly and effectively utilize the principles of applied behavior analysis (K1)
    - Ensure that the newly developed treatment integrity system is consistently used throughout the facility, that data are regularly tracked and maintained, and that minimal acceptable integrity scores are established (K11).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 2/16/11 o DADS Policy#006.2: At Risk Individuals, 12/29/10 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 Policy and Procedure: Medical Emergency Response, 2/17/11, Rev 4/20/11 o EPSSLC Policy and Procedure: Seizure Management Guidelines, 3/18/11 o EPSSLC Policy and Procedure: Medical Care, 2/16/11, Rev 4/27/11 o Mortality Reviews for individuals who died in 2011 o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o Report of external medical review conducted in May 2011 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, quarterly medical summaries, 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 #100,Individual #1, Individual #161, Individual #70, Individual #73, Individual #69, Individual #52, Individual #93, Individual #81, Individual #195, Individual #112, Individual #94, Individual #11, o Medical caseload data o Collaborative Practice Agreement for Advanced Practice Registered Nurse Interviews and Meetings Held: o Ascension Mena, MD, MS, Medical Director o Denise Jones, APRN, FNP o Eugenio Chavez-Rice, MD, Psychiatrist o May Ann Clark, RN, Nursing Operations Officer o Elaine Lichter, RN, Quality Enhancement Nurse o Cynthia Diaz, RN, Nurse Manager o Meeting with medical director, nursing operations officer, QA Nurse, state nursing services coordinator, Valerie Kipfer, and facility director to discuss mortality management

	Observations Conducted: o Observations occurred in various day programs and residences o Risk Management meeting with PST o Medical clinic
	Facility Self-Assessment: The facility's self-assessment, known as the POI, was updated on 7/1/11. It did not include a description of activities the facility engaged in to conduct the self assessment. The POI did not indicate how the self-assessment was used in determining the self-rating. The facility rated itself noncompliant with provisions L1, L3, and L4. It believed it was in compliance with provision L2. The monitoring team found the facility to be noncompliant with all provision items. An action plan was included in the POI. This action plan only addressed three recommendations from the January 2011 visit. Clearly, attention will need to be turned to the concerns raised in this report in order to achieve substantial compliance.
	Summary of Monitor's Assessment: The medical department had made essentially no progress since the previous visit. Further, many of the initiatives that were underway in January 2011 had not moved forward. This was due, in large part, to both of the primary providers working just a few months at the facility. The new medical director was just becoming familiar with the facility, its operations, and the requirements of the Settlement Agreement. As would be expected, many aspects of the Settlement Agreement were not familiar to him. While individuals received basic care, there were significant issues related to the provision of preventive care and transitioning individuals into acute care. Those aspects of this review that required data from the facility were seriously impeded by a lack of good data. In many instances, the monitoring team was informed that data did not exist. In other instances, data were provided that clearly were not adequate. The external medical review was completed in May 2011. This review consisted of six chart audits. Corrective action plans resulting from that process were in the process of being completed. Mortality reviews were completed, albeit completion was 10 months following death for two individuals. It was encouraging to note, however, that the facility identified systemic issues in the reviews and implemented corrective action plans. There was no formal medical quality program and no steps had been taken to assess the quality of medical care provided independent of the external review. The medical director reported that he was developing a template for an internal review. The medical department had not implemented any new policies or procedures since that last review and the state issued clinical guidelines had yet to be released.

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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 department had undergone significant staffing changes since the January 2011 onsite review. Moreover, each of the three monitoring compliance visits was marked by the leadership of a different medical director. The third and current director joined the medical staff in May 2011, just eight weeks prior to the review. A full time advanced practice registered nurse began employment in March 2011. Medical coverage was provided by a locum tenens physician and a contract physician from March 2011 through May 2011. The contract physician continued to provide weekend and intermittent on-call coverage. The medical director reported that a contract had recently been negotiated with a local internist who would provide part-time hours. One full time physician provided psychiatric services. The collaborative practice agreement for the family nurse practitioner was reviewed. This agreement was executed with the physician who provided weekend coverage and not by the facility's medical director. The facility conducted onsite neurology, dental, and psychiatry clinics. Beginning in May 2011, neurology clinic was conducted weekly. A monthly joint neurology-psychiatry clinic was implemented to improve integration of neurological and psychiatric services. Persons who required hospitalization were admitted to University Medical Center. X-rays were also done at the medical center. Wet readings returned with the individual and the official reading was usually completed within 24 hours. The facility had recently contracted with a new local company to provide laboratory services. **General Medical Care and Documentation** The individuals received a variety of medical services. They were provided with preventive, specialty, and acute care services. Several of the requirements of the Health Care Guidelines are discussed below. Over the past four months, medical services were provided by various temporary physicians. <u>Annual Medical Assessments</u> Annual Medical assessments were contained within the integrated active record. Twelve of 12 records contained AMAs that were current. The annual assessments were completed based on a standardized template that was organized into the following sections; (1) active problems, (2) past medical history, (3) review of systems, (4) interval history, (5) medications, (6) labs, diagnostics and consults, (7) immunizations, (8) physical exam, and (9) discussion of problems. The annual medical assessment did not provide a good snapshot of the individual's health status. Problems and diagnostics were usually not connected and medical risks were not discussed.	Noncompliance

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		The plan of care was a statement that was quite similar in all of the assessments reviewed: "Patient is being maintained on chronic medications that have been effective in stabilizing her/his major medical problems to include hypothyroidism, asthma…" Organizing this information would likely improve the quality of the document. Inserting an interval history (what has occurred since the last annual assessment) provides one way of linking all relevant information. Discussion of an individual's interval health history should be organized by active health problems with information presented chronologically. All history – illnesses and other events, diagnostic tests, surgeries, interventions, consultations, medication trials, etc. – should be documented in the discussion of each active health problem. Health issues that are related to each other (e.g., dysphagia, aspiration, pneumonia) should be discussed together. The medical plan of care should include a plan for every active medical diagnosis. <u>Active Problem List</u> Most of the records contained an active problem list. These lists often lacked a major diagnosis for which the individual received treatment. None of the records reviewed contained appropriately updated active problem lists. <u>Integrated Progress Notes</u> Medical providers documented in the integrated progress notes. The notes were usually timed and dated. The notes were not consistently done in SOAP format, were sometimes illegible, and often had unrecognizable signatures and credentials. <u>Physician Orders</u> Physician orders were usually timed and dated. Incomplete orders were not infrequent. Additionally, several orders were noted to have illegible signatures and credentials. **Routine and Preventive Care** Individuals received routine and preventive care. Some areas achieved high rates of compliance, such as vision and hearing screenings. Yearly influenza and pneumococcal vaccinations were provided with high rates of compliance, as well. Compliance with varicella, Zoster, Hepatitis B and Hepatitis A vaccinations seemed more problematic. The medical director reported that the infection control nurse tracked vaccinations, but he believed this system was not adequate. Unfortunately, the facility had not implemented any mechanism of tracking preventive care. The integrated record did not contain preventive care flowsheets and the facility did not maintain any databases for tracking the information. The database used by the previous medical director was no longer functioning.	

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		Data were requested related to cancer screenings and incidence rates for pneumonia and other medical conditions. The data provided did not match the request and in many instances was clearly not accurate. The lack of these documents placed limitations on the extent of this review. This was discussed in detail with state office during the onsite review. The observations below are based on review of 12 comprehensive records, including the integrated active records were reviewed. The facility was not able to provide data to include in this section of the report. <u>Screenings</u> • 12 of 12 records contained documentation of appropriate vision and hearing screenings <u>Prostate Cancer Screening</u> • 2 of 6 males met criteria for PSA testing o 2 of 2 (100%) males had appropriate PSA testing <u>Breast Cancer Screening</u> • 4 of 12 individuals females met criteria for breast cancer screening o 3 of 4 (75%) females had current breast cancer screenings <u>Cervical Cancer Screening</u> • 6 0f 6 females met criteria for cervical cancer screening • 0 of 6 (0%) females complete cervical cancer screening <u>Colorectal Cancer Screening</u> • 6 of 12 individuals met criteria for colorectal cancer screening o 3 of 6 (50%) individuals had undergone colonoscopy for colorectal cancer screening <u>Immunizations</u> • 12 of 12 (100%) individuals received pneumococcal and yearly influenza vaccinations • Documentation of hepatitis and varicella vaccination was inconsistent <u>Additional Discussion</u> Data for determining compliance with preventive care programs was limited. The medical director reported during discussion that he had noted problems with	

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		vaccinations. He was also aware that gynecological exams were not being completed. During the week of the onsite review, he was scheduled to meet with physicians at the medical center to discuss a plan for completing pelvic exams and cervical cancer screening. **Case Reviews** The following three case review summaries illustrate the inconsistent overall provision of medical care at EPSSLC. <u>Individual #52</u> had a history of seizure disorder, hyperlipidemia, osteoporosis, and Down syndrome. The individual was hospitalized in 6/11 with pneumonia. The following are some examples of the findings of the record review: • Cervical cancer and colorectal cancer screening were not completed for this individual. • Breast cancer screening was completed regularly. • An assessment was completed prior to hospital transfer. The signature of the person competing the assessment was not legible. The post-hospital transfer note was completed. • The individual was treated with two loop diuretics for congestive heart failure. Pharmacy recommended that one diuretic be discontinued. The physician accepted the recommendation and the order was written. • The individual did not receive treatment for CHF with an ACE inhibitor or ARB and the records did not reflect a rationale for this. This recommendation was made by pharmacy, but was not addressed. • The Annual Medical Assessment competed 5/11 listed CHF as an inactive problem. The individual received medication for the treatment of CHF. • Multiple verbal orders were noted that were never signed by the medical provider. • On 6/23/11, documents were signed to implement DNR status for this individual. There was no physician note explaining why this was appropriate. No order was written to implement this. <u>Individual #100</u> had a history of seizure disorder, constipation, GERD, osteoporosis, and psychotic disorder. Record reviews indicated the following: • Preventive care was up to date. • The individual was a Hepatitis B carrier, but the diagnosis was not listed as an active problem. The Annual Medical Assessment did not discuss the problem. o Individuals who are Hepatitis B carriers are at risk of reactivating to chronic Hepatitis B infection. There was no documentation of	

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		vaccination against Hepatitis A. • Ferrous gluconate was prescribed for "low iron." This was not discussed in the medical assessment. A diagnosis of colonic angectasia was found in a colonoscopy report. It was believed that this may have caused a GI bleed. Follow-up and monitoring for this was not evident in medical documentation. If iron was prescribed for this reason, the diagnosis of iron deficiency anemia should be added. Critical to that issue was to ensure that the etiology of iron deficiency anemia was clear in a middle aged male. <u>Individual #81</u> had multiple medical problems including seizure disorder, osteoporosis and dysthymic disorder and psychogenic vomiting. A review of the active records showed the following: • Preventive care was current. • Omeprazole was prescribed for the indication of vomiting which was not an appropriate indication. • A severe drug interaction was reported in 4/11, but no documentation was found in the records as required by pharmacy policy. • The individual received alendronate for osteoporosis, but no BMD had been completed in four years. **Do Not Resuscitate** The monitoring team requested a list of persons with current DNR orders, the reason for the DNR order, notes, and supporting documentation. DNR forms were submitted for four individuals. The reason for the DNR status and other requested information was not provided. The facility's process for implementation of DNRs will need to be examined during future visits. **Seizure Management** Neurology clinic was held onsite. A listing of all individuals with seizure disorder was provided to the monitoring team. The list included 85 individuals with seizure disorder. A list of individuals receiving AEDs was provided. A total of 91 individuals received these medications. This included individuals who received AEDs for behavioral reasons and other medical conditions, such as migraine headaches. In several instances, no diagnosis was provided. With regards to drug use: • 44 of 91 (48%) individuals received one AED • 34 of 91 (37%) individuals received two AEDs • 11 of 91 (12%) individuals received three AED • 2 of 91 (2%) individuals received four AEDs • 13 of 91 (14%) individuals received at least one older drug, such as	

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		phenobarbital or dilantin Neurology notes were provided for five individuals. Review of the notes indicated that key information was reviewed with a focus on medication management. Recommendations were provided to the PCP related to medication management. Information related to medication side effects contained in the MOSES and DISCUS evaluations did not appear to be reviewed. One individual who appeared to be seizure free for several years on monotherapy did not have any assessment for discontinuing medications. See Recommendations #1 to #11.	
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.	<u>Medical Reviews</u> The state medical services coordinator completed external medical reviews on 5/13/11. A five percent sample of records (six records) was examined for compliance with 32 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were seven essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. Provider compliance with essential elements was 57%. Nonessential compliance was 67%. Follow-up of corrective action plans was completed by the QA nurse and documentation of this follow-up was provided. The medical director reported that during a medical director's meeting, it was announced that the external audits would be completed every six months instead of quarterly. The review, however, was focused entirely on processes. There were no outcome indicators among the 32 items. Because outcomes of individuals are the primary focus, a quality review must include these. The addition of outcome indicators is critical in determining the quality of medical care provided. In order to standardize this review across the state, consideration should be given to utilizing the same outcome indicator(s) with each review statewide. Selecting clinical outcome indicators based on the state issued clinical guidelines would be an appropriate starting point since these are the high priority issues targeted by the state. <u>Mortality Reviews</u> Mortality reviews were completed by the facility. There was a significant delay in the completion of these reviews. Administrative death reviews were conducted on 6/10/11 and 6/30/11. The four administrative reviews completed on 6/10/11 involved three deaths that occurred in 2010 and one death from March 2011. A log was generated that	Noncompliance

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		consisted of multiple actions to be taken as a result of the recommendations generated by the reviews. Many of the recommendations addressed systemic issues, such as implementation of systems to track appointments and labs, revision of the Code Blue processes, and documentation and improving the bowel management program. Several of the items had been completed and others were in progress. The Administrative Death Review completed on 6/30/11 also resulted in a series of recommendations. The facility's medical emergency response system was cited in several of the administrative reviews. In the January 2011 monitoring report, the monitoring team pointed out that the lack of a standardized recording form made it difficult to record Code Blue events. It was also noted that clinical oversight of the system was lacking because the department of Competency Training and Development conducted the drills. The facility was encouraged to conduct drills to meet the requirements of state issued policy, as this practice was deficient. The recurrence of problems with the medical emergency response system indicated that the system was in need of evaluation and repair. The current mortality review system did not require a physician to complete a thorough review of all records, inclusive of the integrated record, to determine if there was compliance with the standards of care of medical practice. The medical director reported that a contract for completion of mortality reviews had been signed and would include a through external physician review. See Recommendations #12 to #14.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility had not implemented a formal medical quality program at the time of the onsite visit. The medical director reported that policies and procedures were under development. A medical quality program would be established after the implementation of appropriate policies and procedures. No progress was noted in this area. See Recommendations #15 to #16.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18	There had been no progress in this area from the January 2011 visit. Furthermore, during the last visit, the medical director presented several clinical guidelines that were submitted to state office for review. At the time of this onsite review, no clinical	Noncompliance

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	months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	guidelines had been issued by state office and the facility had not developed any clinical guideline or policies independently. The facility's POI indicated that the medical care policies and Health Care Guidelines were being reviewed. See Recommendations #15 to #16.	

Recommendations:

1. The collaborative agreement between the advanced practice registered nurse and medical director should be completed in accordance with state guidelines (L1).

2. Consideration should be given to revising the format of the Annual Medical Assessment as discussed section L1 (L1).

3. The medical plan of care should include a plan for every active medical diagnosis (L1).

4. Active Problem List should be updated in an ongoing manner (L1).

5. The medical staff should be in-serviced on all elements of proper documentation. This includes the requirement to make IPN entries in SOAP format in a legible manner (L1).

6. The pharmacy director and medical director should work with the medical staff to ensure that physician orders are written appropriately and include all required elements (L1).

7. The facility must have a sense of urgency in implementing measures to ensure that all preventive care is provided. This may involve a development of database to track preventive care elements including vaccinations (L1).

8. Preventive care flowsheets should be implemented. The requirements for care should be based on local medical policy and the Health Care Guidelines (L1).

9. The current process for implementing DNR status should be reviewed. The individual mentioned in L1 should specifically be reviewed to determine if the DNR status is appropriate (L1).

10. The medical department should create a seizure database. Medications used for the treatment of seizure disorder should be entered into the

database and updated. Other data such as the dates of seizures should also be entered. This information would be helpful in actual management of individuals as well as in determining the quality of care (L1).

11. Consideration should be given to standardizing the neurology clinic notes to ensure that the information from the MOSES and DISCUS evaluations is taken into account when making treatment decisions (L1).

12. The external medical reviews should be revised to include process and outcome indicators. If the frequency of the reviews is decreased, the sample size will need to be increased (L2).

13. The facility director must ensure that recommendations related to mortality reviews are implemented and followed up (L2).

14. The facility should review its medical emergency response system and focus on the following (L2):
    a. Development of a system that is responsive
    b. Completion of drills that are relevant to the types of events known to occur at the facility
    c. Assessment of drills that includes appropriate corrective actions and follow-up of those actions
    d. A robust system of performing equipment checks
    e. Development of an oversight system that includes involvement of the CNE and medical director. This oversight body would bear the responsibility for system revision, evaluation and corrective actions.

15. A medical quality improvement program needs to be developed and implemented (L3, L4).

16. Clinical guidelines must be implemented. This is the rate limiting step for the development of a formal medical quality program because the desired outcomes must be defined (L3, L4).

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:** <u>Documents Reviewed</u>: o EPSSLC Organizational Chart o Map of EPSSLC o DADS State Supported Living Center Policy: Nursing Services (5/11/11) 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 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 Job descriptions of LVNs, RNs, Nurse Managers, Campus Nurse Supervisor o Schedule of medication pass times as of 7/13/11 o QI Death Reviews for Nursing for Individual #11 and Individual #94 o Nursing Monthly Schedule for 5/1/11-6/30/11 o Nursing Daily Assignments for 5/1/11-6/30/11 o Evidence of Mode Drill recommendations, follow-up, and completions o CT&D schedule of training sessions conducted as a result of no Nurse Educator o Memorandum of Discontinued Use of Tongue Depressors o Nursing Education Handbook o Monthly Medication Room Inspections for 1/1/11-7/14/11 o EPSSLC Self-Assessment: POI 2011 o EPSSLC Meeting Schedule updated 7/10/11, updated o Records and MARs of: • Individual #59, Individual #37, Individual #100, Individual #8, Individual #126, Individual #111, Individual #57, Individual #10, Individual #16, Individual #155, Individual #70, Individual #115, Individual #162, Individual #21, Individual #1, Individual #11, Individual #15, Individual #2, Individual #67, Individual #117, Individual #154, Individual #52 <u>Interviews and Meetings Held</u>: o Opening meeting on EPSSLC progress since 1/11 review o Acting CNE/Nurse Operations Officer, Mary Ann Clark, RN o Quality Enhancement Nurse, Elaine Lichter o Infection Control Nurse, John Chea, RN o Pharmacy Director, Amista Salcido, Pharm.D. o Nurse Manager, Cynthia Diaz, RN o Nurse Manager, Veronica Bahner, RN o Nurse Supervisor Sigrid Ebah, RN

	Observations Conducted: o Visited individuals residing in Dorms A, B, and C, 506, 507, 508, 509, 510, 511, 512, and 513 o Emergency medical equipment in Dorms A, B, and C, 506, 507, 508, 509, 510, 511, 512, and 513 o Medication administration in Dorms A, B, and C, 507, 511, and 512 o Enteral feedings in Dorm C and 507 o PSPAs for Individual #21, Individual #2, and Individual #93 o 7/12/11 Medication Error Committee meeting o 7/12/11 Nurse Meeting o 7/13/11 Mortality Review meeting
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. Across the provision items of Section M, the "Comments/Status" sections failed to describe a comprehensive set of specific actions that were expected to help the Nursing Department achieve the provisions of Section M of the Settlement Agreement. Rather, under each item of the provision, there were lists of discrete events, usually meetings, trainings, and policy revisions, which had occurred over the past year. It was left to the reader to assume what, if any, effect the event/activity had on promoting progress toward achievement of the provisions of the Settlement Agreement. During the conduct of the review, it was apparent that the absence of a well laid out plan to achieve the provisions of Section M had cost the Nursing Department valuable time and put the health and safety of residents at risk. The Chief Nurse Executive, Center Lead for Section M, self-rated the facility as being in noncompliance with all provisions of Section M. The monitoring team was in agreement with these self-ratings. During the onsite review, the presentation book was not reviewed because it was candidly reported that it had not been used by the Nursing Department or revised since the prior monitoring visit.
	Summary of Monitor's Assessment: Since the prior monitoring review, there were a number of changes in the staffing of the Nursing Department. Some that were reportedly planned, and some that were not. As of the current review, because the CNE was out on leave, the NOO was the Acting CNE. In addition, two RN positions were transferred to other departments, there was a significant increase in unscheduled absence and use of voluntary and mandatory overtime, and there was an elimination of the Nurse Educator, Hospital Liaison, and Nurse Recruiter positions in the department. Thus, the roles and responsibilities usually associated with these positions became the additional responsibilities and duties shared by the acting CNE and two Nurse Managers. Notwithstanding these significant changes and challenges, the good news was that the nursing leadership had held fast to their commitment to improve nursing care for the individuals, and they have tried to

	continue to move forward toward achieving the provisions of the Settlement Agreement. They had, and continued to, work hard. And, they had continued to closely collaborate with the Director of the Pharmacy and the Quality Assurance Nurse. As a result of their continued hard work and collaboration, there continued to be improvement in performance and progress toward the achievement of provision M6. Unaccounted for medications and omissions, shortages, and overages of medications decreased, and the accountability of medications increased. Notwithstanding these positive findings, the review revealed many problems in nursing care that raised serious concern over the department's functioning, its capacity to ensure the health and safety of the individuals, and its ability to move toward compliance with the provisions of the Settlement Agreement, which articulated the basic, accepted standards of nursing practice. For example, the review revealed nurses failed to consistently perform complete assessment of individuals with significant changes in their health and failed to ensure timely and appropriate care and treatment. Egregious violations of infection control were observed, and, across the facility, the emergency medical equipment was in complete and total disarray. Also, nurses were woefully unprepared during individuals' interdisciplinary meetings. These lapses resulted in delayed assessment and planning to address individuals' health risks and delayed implementation of at least one individual's plan to transition from enteral to oral feeding. There were many more findings and areas where nursing care had not met standards of practice and where progress toward compliance had not occurred and may have actually declined.

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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 had continued to articulate a commitment to improve performance and achieve compliance with this provision of the Settlement Agreement. Since the prior monitoring review, although EPSSLC reported that it was "monitoring and evaluating" and "tracking and trending" further educational needs in this area, progress had not been made toward meeting this provision item. As noted during each of the prior monitoring reviews, there continued to be a persistent pattern of problems ensuring identification of health care problems, performing complete assessments, implementing planned interventions, conducting appropriate follow-up, and keeping appropriate records to address the significant changes in residents' health status and needs. Thus, a rating of noncompliance was made. During the conduct of this onsite monitoring review, all dorms and cottages were visited, 13 nurses were interviewed, and 20 individuals' records were reviewed. As noted in the prior review, all individuals' records were organized in a unified form/format. Individual notebooks were present and available to direct caregivers. Notwithstanding these positive findings, the onsite review of records was challenged by the absence of records on the dorms and cottages for extended periods of time throughout the day and early evening shifts. Across the dorms and cottages, it was not uncommon to find anywhere from one or two to over one-half of the residents' records to be missing from the shelves.	Noncompliance

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		According to a review of the record log books, the records were usually signed out to the clinic and absent from the dorm/cottage for most of the day. In addition, the off-site review of records was challenged by the glaring absence of many documents and the overall disorganization of records provided to the monitoring team for review. For example, over 75% of the records requested by the monitoring team were missing multiple pages of IPNs, nursing assessments, care plans, PSPAs, etc., and several individuals' records were mixed with portions of the records of other individuals. The monitoring team requested that the facility verify that the residents' records were indeed completely copied and organized, as they existed on the shelves. In response to this request, the facility provided some piecemeal documents, but failed to verify the integrity of the record submission. The Nursing Department's POI referenced that since the prior monitoring review, several "training sessions" were conducted in an effort to improve the facility's nurses' documentation of progress notes, assessments, and care plans. The review of individuals' records, however, revealed that the legibility of nurses' notes, signatures, and credentials had not improved. Also, across all records reviewed, it was evident that although the nurses had changed the documentation of their notes from DAP to SOAP format, they still 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. Across the 20 individuals' reviewed, there was significant decline noted in the nurses' timely notification of the individuals' physician of changes in the individuals' health status and needs in a timely manner. Also, there continued to be 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. In addition, there were a number of occasions where the only references of follow-up to resolution of significant changes in individuals' health status were follow-up notes by the "med clinic." Thus, there were delays in the assessment, treatment, and follow-up of individuals' health needs and risks. Also, although the Nursing Department reported that all nurses were required to review the 24-hour shift report, specifically the reports of individuals with 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 the reports were incomplete and many nurses failed to consistently avail themselves of every opportunity to exchange and receive information. Thus, it was not surprising that several direct care nurses were not aware of residents'	

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		changes in health needs and risks. For example, during the monitoring team's observations of several nurses' performance of their job duties, upon questioning, it was apparent that the nurses were not knowledgeable of the health status of various residents who were assigned to their care, and their prescribed treatment and monitoring of conditions such as infection, head injury, and altered skin integrity. 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. In addition, the DADS Nursing Services Policy and Procedures stipulated that nursing staff members will document all health care issues and will have follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem has resolved. Notwithstanding these requirements, 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, there were numerous instances when 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. The following examples were typical for many individuals 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 4/15/11, at 4:00 am, Individual #70's direct care staff member reported to his nurse that Individual #70 was in bed crying. Individual #70's nurse failed to conduct a complete assessment and failed to obtain a complete set of vital signs. On the basis of little to no assessment of Individual #70's health status, his nurse concluded that he may have "possible pain," administered 1,000 mg Tylenol, and noted that he/she would "continue to monitor." One-half hour later, Individual #70's nurse noted that he/she "reassessed" Individual #70, and again, absent any evidence that he/she obtained and evaluated Individual #70's vital signs and other indicators of his health status, his nurse concluded that he had "no signs of distress." Several hours later, another nurse, who came on duty, noted that Individual #70 was "warm to touch," "pale in color," and "lethargic." At this time, Individual #70's temperature was significantly elevated (101.2). Individual #70's physician was notified and he was transferred to the hospital where he was diagnosed with bacterial meningitis and septicemia.	

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		• On 2/17/11, Individual #10's nurse noted that he had positive reaction to his tuberculin skin test, which reportedly measured 40 mm. According to Individual #10's nurse, he/she reported this finding to Individual #10's nurse practitioner, who "ordered [Individual #10] to be seen in clinic tomorrow." On 2/18/11, there was no evidence of a face-to-face evaluation of Individual #10 at the clinic, but Individual #10's physician ordered a repeat PPD test in two weeks. There was no evidence that Individual #10 received another PPD test, but he did undergo a chest x-ray on 3/1/11, which revealed opacities in his left perihilar and peripheral regions. On the basis of these findings, Individual #10's nurse practitioner ordered a CT scan of his chest, which was not completed until 4/8/11. Individual #10's CT scan revealed several significant findings that included possible aspiration, superimposed pulmonary infection, and evidence of prior granulomatous disease. On 5/24/11, over three months after Individual #10's conversion from a negative to a positive tuberculosis skin test, the facility's Infection Control Nurse's noted his plan to "follow-up" on the 2/17/11 positive TB test. Although the Infection Control Nurse "ordered sputum for AFB (acid fast bacillus) in AM on 5/25/11," it was not until 5/31/11 that Individual #10's sputum was obtained for testing, and it was not until 6/6/11 that his physician noted that the findings were negative. Throughout this four-month ordeal, despite evidence of multiple risk factors indicative of the presence of possible contagious, infectious disease – decreased appetite, weight loss, fatigue, positive PPD, fluctuating blood pressure and blood sugar levels, etc. - there was no evidence that the significant changes in Individual #10's health status were adequately and consistently assessed and monitored and/or that interventions were implemented and follow-up activities occurred in a timely manner to ensure the health and safety of Individual #10 and those who were in contact with him. • On 4/29/11, Individual #126's physician ordered that her nurses "monitor and document closely for gait instability." Notwithstanding this order, a review of Individual #126's record revealed that there were no nurses' notes documented from 4/29/11 until 5/10/11 when it was noted that Individual #126's physician saw her "unsteady, leaning to the left, confused, and hitting the wall when walking" and ordered her transfer to the hospital. • On 3/13/11, at 1:30 pm, Individual #162's physician ordered monitoring of his "lungs and vital signs every four hours until seen in the clinic," in follow-up to Individual #162's possible aspiration event. There was no evidence that Individual #162's significant change in health was monitored in accordance with his physician's orders.	

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		Regarding numerous individuals A critically important feature of ensuring adequate, appropriate, and timely response to medical emergencies is the presence and availability of functioning emergency medical equipment. A review of the state of affairs of medical emergency equipment at EPSSLC revealed serious problems. For example, the medical emergency equipment for Dorms A, B, and C was not stored in one central location. The defibrillator, backboard, PPE, suction machine with tubing and water, oxygen with mask, and gloves, flashlight, pulse oximeter, stethoscope, and blood pressure cuff were all stored in separate locations. This had the potential to create situations where precious time may be lost during medical emergencies. Across all cottages, medical emergency equipment was in disarray. This finding was corroborated by several cottage nurses who reported, "Everything was moved around during remodeling [of the cottages]." Four of the eight cottages failed to have suction machines, and the other four cottages had suction machines, but no water immediately available. Across all cottages, there were problems with the availability of gloves, working flashlights, and oxygen tanks, many of which were not properly secured and some of which were empty. In addition, the daily checks of emergency equipment was either incomplete or, in some cases, indicated that important pieces of emergency medical equipment were "0" (not present) for lengthy periods of time. Of note, there was no evidence in any of the nursing reports, meetings, minutes, etc. that indicated that the Nursing Department had identified and/or addressed these serious problems.	
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. In accordance with the provisions of the Settlement Agreement, the DADS Nursing Services Policy and Procedures (effective 5/11/11) affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized comprehensive nursing assessment forms in use at EPSSLC referenced the collection, recording, and analysis of a complete set of health information that led to the identification of all actual and potential health problems, and to the formulation of nursing diagnoses for the individual. However, at EPSSLC, it was reported by both direct care nurses and nursing leadership, that they were only required to document IPNs "by exception," which meant that they	Noncompliance

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		were only required to document episodic notes written in response to narrow, specific, and significant changes in residents' health status and needs. This report, however, failed to align with the DADS Nursing Services Policy and Procedures that specifically stated that all nursing actions and interventions would be promptly documented in the clinical record, in accordance with all applicable legal standards, State Center policies, DADS procedures, and professional standards. In addition, the state's policy directed nursing staff members to document their reviews of the effectiveness of ongoing treatments and individuals' responses to treatments. Also, the state's policy indicated that exacerbations of chronic conditions required weekly monitoring for a minimum of one month. The Health Care Guidelines did not prescribe an exact "right" frequency or format for reporting and recording an individual's progress, but they did indicate that a review of the record should reveal each individual's progress in maintaining or improving functional abilities, which includes both health and psychosocial status. They also indicated that the clinical record should document change toward achieving care plan goals and provide adequate progress information necessary for the staff members to work with the individual. This certainly implied that regular progress information was necessary in order to assess/evaluate the adequacy and appropriateness of the care plan as it was reviewed quarterly vis a vis the quarterly nursing assessment. Quarterly and annual nursing assessments existed in each of the 20 sample individuals' records. However, all 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 treatments, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. 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. As a result, a rating of noncompliance has been given to this provision item. Across all of the 20 sample individuals reviewed, comprehensive nursing assessments had many of the deficiencies described below: • Current active problem lists were incomplete and not up-to-date, • There were not meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments, • Dates and results of mealtime monitoring were blank or documented with limited, uninformative phrases, such as "Negative for coughing and choking."	

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		• When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status, • Tertiary care reviews were incomplete, • Individuals' significant histories of chronic and acute conditions, including, but not limited to, aspiration pneumonias and cancers, were not completely identified and evaluated, • Erroneous information frequently obtained and documented during physical assessments, such as assessment indicated individual was incontinent of urine, but he had an indwelling foley catheter; assessment failed to note that individual suffered from frequent urinary tract infections; assessments inaccurately indicated failed to note that individuals suffered from severe constipation, assessment erroneously indicated individual had a gastrostomy tube and received enteral feeding when he did not; and assessment erroneously indicated that individuals with generalized joint contractures and spasticity had no musculoskeletal abnormalities. • Nursing assessments that indicated that nonverbal individuals' pain might be determined by their self-injurious behavior and gestures, failed to reference 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, constipation, insomnia, etc., were usually noted by their nurses in the nursing assessments, but frequently the nature and extent of these problems was not accurately portrayed and not adequately evaluated, diagnosed, or addressed vis a vis care plan(s). • Lists of nursing problems/diagnoses were incomplete and, occasionally, referenced problems/diagnoses that were not identified or revealed during the comprehensive assessment or elsewhere in the individuals' records. • Nursing summaries were run-on sentences and/or lists of discrete events, such as medication changes, appointments, lab test results, clinic visits, etc., and failed to provide an organized, thoughtful, recapitulation of the individuals' health status over the quarterly review period and failed to put forward nursing interventions/recommendations to address the individuals' progress/lack of progress toward the achievement of their desired health outcomes. The following examples from this sample indicated the seriousness of this problem at EPSSLC. • Individual #117 was a 64-year-old man diagnosed with many health needs and risks that included cerebral palsy, quadriplegia, contractures, seizure disorder,	

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		osteoporosis, constipation, hypoalbuminemia, vitamin D deficiency, hypertension, large hiatal hernia, diverticulitis, Barrett's esophagus, right hydronephrosis, myelodyspoastic syndrome (pre-leukemia), and history of aspiration pneumonia. His quarterly nursing assessment did not reference all of his current active problems, and it failed to evaluate his response to and the effectiveness of his medications and treatment, save for the words "Therapeutic" and "Good." In addition, despite the seriousness of Individual #117's health needs and risks related to his (1) history of aspiration pneumonia, (2) diagnosis of Barrett's esophagus, which was strongly associated with esophageal carcinoma – a particularly lethal cancer, and (3) hydronephrosis and need for an indwelling catheter, which caused him to suffer penile erosion that resulted in hypospadias - a break or gash in his urethral opening, none of these were referenced or addressed in his nursing assessment. • Individual #67 was a 64-year-old woman who, over the past year, suffered from recurrent episodes of alteration in skin integrity, such as pressure ulcers on her buttocks and cellulitis of her left leg and right arm. In addition, she was diagnosed with generalized anxiety, hypertension, vitamin D deficiency, Chilaiditi's Syndrome (pain due to transposition of the large intestine), erosive esophagitis, hiatal hernia, osteopenia, excessive salivation, sinus tachycardia, and left breast mass. In October 2010, Individual #67's dentist noted that she had "large decay, heavy calculus – generalized and barnacle type" and would not cooperate for dental care/treatment on 5/19/11, 5/24/11, and 6/1/11. Despite these many health needs and risks, Individual #67's quarterly nursing assessment was incomplete and missing information pertinent to an evaluation of Individual #67's tolerance of food/fluids, receipt and outcomes of tertiary care, behavior challenges, alteration in skin integrity, and infection. The genito-urinary and gynecology sections of Individual #67's nursing assessment were also blank. In addition, no nursing diagnoses/problems were identified as a result of Individual #67's assessment. • Individual #100 was a 52-year-old man diagnosed with psychotic disorder, oppositional defiant disorder, insomnia, seizure disorder, GERD, hiatal hernia, constipation, osteoporosis, severe hearing loss, and akathisia – a feeling of restlessness and inability to sit still. Over the past six months, Individual #100 suffered a 34-pound weight loss. On 11/13/10, his physician recorded his weight at 160 pounds, and on 6/8/11, his dietician recorded his weight at 126 pounds. In addition, it was noted by various clinical professionals that Individual #100 frequently refused meals. Individual #100's nurse reported in his quarterly nursing assessment, "[Individual #100] has had some weight loss past couple months and weight notifications were sent out by this nurse on 3/31/11, 4/27/11, and 5/10/11. Indeed, there was evidence that weight	

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		gain/loss notification forms were sent to Individual #100's physician, QMRP, NOO, NMT, dietician, and food services, but there was no evidence that Individual #100's nurse, as part of his/her assessment, evaluated or analyzed pertinent health data, such as Individual #100's meal refusals, intake/calorie counts, amount of daily exercise/activity/daily caloric expenditure, behavior data, etc. to help identify patterns/trends, which may have helped to the development of planned interventions/strategies to effectively address his weight loss. Notably, weight loss/management was not included in Individual #100's list of current nursing diagnoses/problems.	
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.	According to the facility's POI, Section M3, since the prior review, the CNE participated in a Quarterly CNE meeting in which the development of a workgroup to address the development of nursing care plans was discussed. In addition, the CNE reported, "Competency training/instruction on care plans available in nursing education handbook." It was unclear how the presence of training curriculum in handbook could, or would, help the facility ensure that individuals had adequate and appropriate nursing/health care plans to address each of their health care needs, which were promptly implemented and revised as indicated. According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. 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. Nineteen of the 20 individuals reviewed had some of their health needs and risks referenced in Health Management Plans (HMP) and/or Acute Care Plans (ACP). For one of the 20 individuals, there was no evidence of his HMP. Health Management Plans were usually assembled by the individual's 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 continued to be largely due to the persistent pattern of failure to: • incorporate all relevant data from systems' assessments into the HMPs and ACPs, • reference all health risks and actual problems in the HMPs and ACPs, and	Noncompliance

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		• update HMPs and ACPs as needed to ensure they addressed all current health needs at all times. Some general comments regarding the 19 sample individuals with care plans are presented below. • Across the 19 sample individuals reviewed, despite the reported presence of "Care Plan Library," HMPs and ACPs continued to vary in form/format. Some of the HMPs and ACPs were of the current, preferred, and state-approved form/format, but a number of them were not. • Across the 19 sample individuals reviewed, HMPs and ACPs were not consistently dated with the date(s) of implementation, review/revision, and/or resolution. • None of the 19 sample individuals reviewed had HMPs that consistently addressed all of the health care needs of the individuals and, when appropriate, ACPs consistently prepared in a timely manner, or at all, in response to individuals' acute and/ or emergent health care needs and risks. • Fifteen of the 19 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, there were only two instances where the HMPs were revised to reflect the most current conditions and intervention strategies. • For over three-fourths of the 19 sample individuals reviewed, there was no evidence that, at least quarterly, individuals' nurses conducted a comprehensive review of the individuals' HMPs and current ACPs to ensure that 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 vaguely stated goals that were sometime confused with interventions and nursing and direct care staff member duties. In addition, goals were not individualized, and they did not reflect the individuals' participation in their development. • To date, there was evidence that only three of the 19 sample individuals had participated in the new PSP process for the assessment of risk and development of risk action plans to address areas identified as high risk. Thus, similar to the findings in the prior review, the health sections of 16 of the 19 individuals' PSPs, as well as the summaries of their PSPAs, which were held to address health/medical/risk issues, were not informative, current, accurate portrayals of the individuals' health risks across all risk areas (see Section M5 for more	

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		information regarding this issue). Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #8 was a 43-year-old man who suffered recurrent injuries, such as laceration and bite wounds, as a result of self-mutilation. Despite his risk of and actual skin infections including MRSA, he did not have a HMP in place to address his actual and potential alterations in skin integrity. • Individual #8 also was diagnosed with hyponatremia, which his physician opined was related to SIADH (syndrome of inappropriate anti-diuretic hormone hypersecretion) and recommended an evaluation of water restriction. Individual #8's condition was apparently not well understood by his RN case manager who, on 3/4/11, implemented a "Risk for Dehydration" HMP that called for increased fluids with a "goal of 2.5 liters per day" to address his hyponatremia. It was recommended that Individual #8's RN case manager collaborate with Individual #8's clinical professionals to ensure that his hyponatremia was appropriately and safely addressed and managed. • Individual #34 was a 54-year-old woman diagnosed with Down Syndrome. She was also diagnosed with many of the chronic health needs and risks that were associated with aging individuals with Down Syndrome, such as dementia (Alzheimer's type), congestive heart failure, mitral valve insufficiency, obstructive sleep apnea, osteoporosis, GERD, hypothyroidism, constipation, etc. A review of Individual #34's record revealed that she failed to have HMPs to address her dementia, hypothyroidism, GERD, and alteration in skin integrity. In addition, her HMPs related to obstructive sleep apnea and psychotropic medication side effects were not revised to reflect changes in her treatment interventions and medication regimens. • Individual #16 was a 36-year-old man who was diagnosed with diabetes, hypopituitarism, obesity, edema, hyperlipidemia, hypothyroidism, hypogonadism, GERD, seizure disorder, constipation, hypoalbuminemia, and alteration in skin integrity. In addition, Individual #16's mobility was impaired due to his inability to weight bear, flaccid lower extremities, and foot drop. Despite his multiple health needs and risks, he did not have HMPs to address his GERD, seizure disorder, constipation, and immobility. In addition, although his HMP related to obesity referenced that his nurses chart at least once a week regarding his response to encouragement to exercise and weight loss, there was no evidence of this monitoring. Also, Individual #16's HMP related to diabetes referenced that his nurses would weigh him weekly, but there was no evidence that this intervention was implemented. • Individual #117 was a 64-year-old man who had many health needs. Over the past several months, Individual #117 suffered urinary catheter induced inferior	

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		penile meatus erosion. On 4/21/11, according to Individual #117's urologist, he had developed hypospadias from the catheter. After six weeks of treatment, on 5/26/11, Individual #117's nurse practitioner noted that his wound had healed. On 6/23/11, Individual #117's discontinued his care plan because his "skin [was] intact." Thus, as of the review, there were no plans in place to address Individual #117's high risk of alteration in skin integrity and risk of serious consequences that he may suffer with the re-occurrence of a penile wound. It was strongly recommended that Individual #117's nurses develop an individualized plan to address this significant health risks. Of note, the HMP that was previously filed in Individual #117's record and discontinued by his nurse was nothing more than a generic "Decubitus Ulcer" plan that referenced not one of the specific, individualized interventions that were developed and/or ordered by his clinical professionals to address his particular health problem. It was strongly recommended that should this generic plan be used again that Individual #117's nurses adequately and appropriately individualize the plan to meet his specific needs.	
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.	Since the prior monitoring visit, the nursing assessment and reporting protocols at EPSSLC, which were in place, had undergone significant change due to the vacancies and subsequent elimination of nursing leadership positions and the expectation that those nurses who remained in positions of nursing leadership would assume the significant roles/responsibilities of these positions. For example, since the prior monitoring review, the facility eliminated the positions of Nurse Educator and Hospital Liaison. Although the Nurse Managers and nursing supervisors were delegated these duties, as of the review, their job descriptions had not been revised to reflect these changes. In regard to vacancies in the Nursing Department, as noted in the prior review, EPSSLC continued to report a reduction in the raw number of vacant nursing positions. As of the review, EPSSLC reported that there were only two vacancies in the nursing department – one RN and one LVN. However, during the conduct of the review, it was reported that, since the prior monitoring review, unscheduled absences were on the rise, voluntary and mandatory overtime to cover unscheduled absence was implemented, and the use of agency/contract nurses to address nursing staff shortages was abruptly curtailed. In addition, the NOO had assumed the additional responsibilities of acting CNE. These events 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	Noncompliance

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		evident in the 20 records reviewed. As of the current monitoring review, although the remaining nursing leadership (i.e., the acting CNE and the two Nurse Managers) continued to front positive attitudes, dedication, and commitment to quality nursing care, their ability to move forward toward achieving the provisions of the Settlement Agreement was significantly held back by their daily struggles to address problems with staffing, morale, and nursing conduct and performance. The facility's Department of Nursing has continued meeting on a monthly basis, however, it was reported that the facility's nurses had not found these meetings to be productive and/or good use of their time. As such, the acting CNE planned to change the format of these meetings from discussions of the results of various monitoring tools and oversight activities to educational forums, which were reportedly preferred uses of the nurses' time. To date, only one monthly meeting under the new format had occurred. On 7/12/11, the facility's new Medical Director conducted a training session/presentation entitled, "Malpractice: Identification and Approach." According to the facility's POI, since the prior monitoring visit, only two activities were implemented to address this provision of the Settlement Agreement – the acute illness and injury policy was introduced (2/23/11), and the acute illness and injury policy training was provided (3/22/11). There was no evidence or reports of any other new initiatives undertaken or underway to help communicate expectations for the delivery of quality nursing care to the facility nurses. As reported during the prior monitoring review, the acting CNE affirmed that over the past six months, there continued to be a focus on enforcing expectations for nurses to comply with basic standards of nursing practice. The acting CNE and two Nurse Managers reported that they continued to spend considerable time and effort working with other disciplines in an attempt to create and shape systems of communication and collaboration between departments and among members of the interdisciplinary team. This collaboration had worked especially well with the Pharmacy Department, specifically through the Nursing Department's collaboration with the Director of the Pharmacy, and with the Quality Assurance Department, specifically through the Nursing Department's collaboration with the Quality Assurance Nurse. There continued to be challenges and frustrations among the ranks of the nursing supervisors and nurse case managers, who had not yet achieved successful implementation of the recommendation to coordinate the timetable of nursing assessments and QMRP quarterlies such that the activities overlapped and duplicative processes were reduced. According to reports of nurse case managers, a few nurses were able to coordinate their quarterly nursing assessments with their QMRP's reviews, but many were not. Some of the barriers that stood in the way of successful	

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		implementation of this recommendation were poor planning for implementation, difficulty working out schedules with some of the QMRPs, and constant changes in scheduled activities. As of the time of this review, these barriers persisted. As noted above, over the past six months, the Nurse Educator and Hospital Liaison positions were reportedly eliminated. Their absence had created a significant absence of education and training in health and nursing care and lapses in the coordination of care and monitoring of individuals who were hospitalized. For example, a review of the results of 28 nurses 2011 competency scores revealed that 64% of the nurses scored less than 80% in one or more areas, such as enteral feeding, urinary catheters, seizures, medications, blood glucose monitoring, etc. No one in the Nursing Department had identified or addressed this sobering finding. Other examples of the failure of the facility to ensure adequate and appropriate education and training and basic competence of nursing staff were revealed during the monitoring team's review of records. For example, a nurse noted that he/she observed what "looked like phlem (sic)" in an individual's closed urinary drainage system. Notably, "phlegm" is limited to mucus produced by the respiratory system. Two nurses on two separate occasions inaccurately documented that an individual, who was hospitalized, was receiving treatment for "neuro-lipid" syndrome rather than neuroleptic malignant syndrome. Another nurse, who apparently lacked knowledge and training regarding the significance of the underlying factors that may contribute to fluid/electrolyte imbalance, implemented an HMP, which included interventions that contradicted the individual's medical specialist's recommendations. Also, when the monitoring team asked to review the training and education materials and curricula, a large binder containing the newly revised and implemented Nurse Education Handbook was provided. The handbook was comprehensive and well organized. Although it was available to any and all nursing staff members, it was not used at EPSSLC. As noted above, nurse managers and supervisors continued to cover the duties of the Hospital Liaison. The nurse managers and supervisors reported that they had not visited individuals in the hospital during their stays. Rather, they periodically obtained some, albeit limited, daily verbal reports from the hospital nurses regarding individuals' status and response to treatment. As noted in the prior review, there was no evidence that contact was consistently made and no evidence that adequate monitoring of the individuals' status and response to treatment while hospitalized had occurred.	

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		During the prior monitoring review, it was noted that one area of assessment and reporting protocols that showed significant improvement was the area of Infection Control. Since the prior monitoring visit, however, there was significant decline in the development, coordination, implementation and evaluation of the facility's infection control program. The absence of the CNE, who was the Infection Control Nurse's supervisor, and the IC Nurse's expanded role during NEO, may have had some bearing on the decline. For example, a review of the minutes of the 12/10 – 6/11 quarterly Infection Control Committee meetings revealed lengthy discussions related to (1) repeated requests for designated direct care staff member(s) to attend the meetings, (2) the "night time diaper free policy," and (3) the persistent failure of designated supervisory staff members to conduct and report on their monitoring of hand washing and peri-care/skin breakdown. Despite the quarterly discussions and repeated recommendations made by the committee to address concerns in each of the above-mention areas, as of the review, (1) direct care staff members were not attending the quarterly meetings, (2) the night time diaper free draft policy was "tabled" without explanation, and (3) monitoring of hand washing and peri-care/skin breakdown failed to occur as planned. Also, during each quarterly meeting, the round-table discussions were cut short and the critically important reviews of data depicting the patterns and trends of infections across the facility were limited to distributions of surveillance data without discussion. The IC Nurse reported he continued to attend direct care staff members' and nurses' shift reports, review physician's orders, visit individuals diagnosed with infections, and document his evaluation, interventions, and recommendations in the individuals' IPNs. However, it was unclear whether or not the IC Nurse continued to receive reports of occurrences of infection in a timely manner. For example, a review of the 20 sample individuals' records revealed at least two individuals (Individual #115 and Individual #10) where the IC Nurse failed to evaluate, intervene, and ensure timely follow-up of possible contagious, infectious diseases. These significant delays put the health and safety of the individuals and others at risk. Also, over the past six months, the IC Nurse made little progress toward ensuring that individuals were properly immunized, in accordance with the Health Care Guidelines. Other than the IC Nurse's periodic review of the facility's clinic's immunization data, there were no systems in place that would move this along and help protect individuals from suffering vaccine-preventable diseases. During an interview with the Quality Assurance Nurse, over the past six months, she provided extensive consultation to and collaboration with the Nursing Department. In	

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		addition, she completed Death Reviews, which 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 prepare corrective action plans in response to the important recommendations put forward in these reports. The QA Nurse's Death Reviews also identified systemic problems related to the presence, availability, and functioning of emergency medical equipment across the facility. Although she astutely recommended that the facility "…develop a plan to include identifying inventory of emergency equipment/materials/supplies and a protocol to routinely assess equipment for proper functioning and consider purchase of emergency response equipment (i.e., suction machine with emergency material/supplies for each dorm and cottage)" as of the review, there was no evidence of follow-up to her recommendations (see section M1 for specific findings pertaining to emergency medical equipment at the facility). The QA Nurse also continued to work hard conducting monitoring and evaluation of assessment and reporting protocols across 12 areas of care, such as seizure management, management of chronic respiratory distress, pain management, urgent care/ER visits/ hospitalizations, acute illness and injury, documentation, medication administration and documentation, skin integrity, infection control, care plans, assessments, and prevention. She had submitted her data/findings to the facility's QA data analyst for analysis and reporting, but there was no evidence that these data/findings were shared with the Nursing Department. Also see comments in section E of this report. On a positive note, since the prior review, the Nursing Department had embraced the knowledge, expertise, and contributions of the QA Nurse. The acting CNE firmly stated her desire to continue to ensure consistent collaboration, communication, and coordination of improvement efforts with the QA Nurse and QA Department.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated	At the time of the monitoring review, EPSSLC was seven months into its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process. According to the facility's POI, Webinar training on the state's health risk policy and procedures was provided and the two Nurse Managers attended and successfully completed the training course offered to Nurse Educators across the state. EPSSLC had also implemented the Health Risk Assessment Rating Tool. During the conduct of the review, the monitoring team attended a two PSPA meetings, which were held as a result of significant changes in individuals' health status and needs.	Noncompliance

#	Provision	Assessment of Status	Compliance
	reviews as indicated by the health status of the individual.	Both of the QMRPs who chaired the meetings were prepared, organized, and participated in keeping the meeting discussion focused and on track. Although the QMRPs gave some of that role/responsibility to the individuals' clinical professionals, it did not take away from the process. The conduct of the RN case managers who participated in the PSPAs needed improvement. For example, during Individual #21's PSPA, the nurse case manager came to the meeting somewhat prepared, but frequently did not have a well-informed and/or well-formulated opinions regarding the individual's level of risk for particular areas of her health status. In addition, despite the presence of the nurse case manager at the meeting, it was Individual #21's physical therapist who repeatedly prompted the individual's team members to discuss her health needs and risks. For all intents and purposes, it appeared as though no review and/or discussion of Individual #21's health risks would have occurred had the physical therapist not attended the meeting. Individual #2's nurses failed to perform and document their monitoring of her response to and tolerance of trial oral feedings, as ordered by Individual #2's nurse practitioner. This failure was not noticed by anyone, including the RN case manager, who was assigned the responsibility of bringing the results of Individual #2's health monitoring to the PSPA meeting. Thus, the RN case manager came wholly unprepared and, as a result, delayed the evaluation, planning, and implementation of Individual #2's transition from enteral to oral feedings. All 20 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and several individuals reviewed were referred to as having one or more "high" health risks. However, since 1/1/11, only three of the 20 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across the above-referenced health and behavior indicators. Also, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated as noncompliance. Examples included the following: • Over the past several months, Individual #70 had suffered significant changes in his health status. For example, he was hospitalized with bacterial meningitis and septicemia, and he suffered persistent fecal impactions, hyponatremia, urinary tract infection, anorexia, stomatitis, stage II decubitus, and significant weight loss. Despite these many negative health events and health risks, there was no evidence of an assessment of Individual #70's health risks and/or development and implementation of a risk action plan to meet his needs. Of note, Individual	

#	Provision	Assessment of Status	Compliance
		#70's 1/11/11 PSP no longer accurately portrayed his health needs and risks, and there was no evidence that PSPA meetings were held to discuss his medical/health needs and risks. • According to Individual #111's 7/2/10 annual medical evaluation, she had barely functioning gait and was using a wheelchair. More recently, on 3/25/11, her psychiatrist noted that she had become "more unsteady and three falls last week." Over the next three months, Individual #111 suffered several additional falls that were usually accompanied by a head injury. In addition, over the past six months, she had an unplanned weight loss of greater than 10% of her body weight. Despite these health needs and risks, as of the review, Individual #70's fall risk remained "medium," and despite her continued weight loss, the action plan to address her high risk of weight loss was unchanged. • Since Individual #8's 2/1/11 risk assessment, he lost almost 30 pounds and also suffered cellulitis, conjunctivitis, and abscessed ear. Nonetheless, as of the review, his risk related to weight loss remained "low," and despite his recurrent infections, his 2/1/11 action plan to address his high risk of infections was not reviewed/revised.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The administration of medication and the management of the medication administration system at EPSSLC had continued to improve 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 generally accepted professional standards of care and the Health Care Guidelines, the facility had taken several steps toward 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, 507, 511, and 512. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		to administration. • 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 the monitoring team's observation of medication administration on Dorm A, an individual was observed with a towel over her face that covered her mouth, nose, and eyes. When the nurse and direct care staff member were asked why the individual had a towel across her face, they replied that it was because "she spits." This practice was not an appropriate intervention to address the individual's behavior challenge and certainly not an intervention approved by the facility's policies and procedures. This conduct was unacceptable and reported by the monitoring team to nursing leadership. • For all individuals across all residential areas observed, the implementation of the facility's 3/28/11 plan to discontinue the use of tongue depressors and to administer oral medications and use durable, non-disposable spoons (aka mother care spoons) for medication administration for all individual who were identified as needing this utensil had gone awry on many levels. o There were too few spoons available during medication administration to accommodate the identified individuals. o There were <u>no spoons</u> available for individuals who were not identified as needing a durable special spoon. o The cleaning and disinfecting of the durable spoons completely failed to meet standards of infection control. For example, some spoons were left for hours sitting on the counter in the medication room(s) "soaking" in cupfuls of tepid water and hand soap, some spoons were sprayed with "Disolv," a hazardous cleaning chemical unsafe for contact with skin and pets and not to be used on porous surfaces; and other spoon were altogether rinsed, wiped with paper towels, and stacked in plastic cups. o The entire process was in dire need of complete review and revision, beyond the 7/14/11 Nursing Department memorandum, to ensure the safe and appropriate administration of oral medications. According to minutes from the Medication Error Committee, there continued to be ongoing monitoring of the nurses medication administration practice to increase oversight and address deficiencies in practice, and nurses' counting and documenting of	

#	Provision	Assessment of Status	Compliance
		individuals' medications. As noted in the prior review, not one of the monitoring reviews had resulted in a score less than perfect/near-perfect. Nonetheless, there continued to be problems with safe and accountable administration of medications. The review of 20 sample individuals 5/1/11 – 7/10/11 MARs revealed that 15 of the 20 individuals had multiple missing entries in their MARs, which indicated numerous potential medication errors in the administration of seizure medications, laxatives, psychotropics, calcium/vitamin D, diabetes medications, anti-hypertensives, eye drops, etc. 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, with some deviations, continued. Thus, they concluded that the steps that were taken had indeed improved the accountability of medication administration and decreased medication errors/variance. For example, since the prior review, bin exchanges were spread out over a four-day, versus three-day, period, medication administration times were changed, medications dispensed for individuals going out on pass included copies of their medication profiles, and during pharmacy technicians rounds, extra bottles of liquid medications were returned to the pharmacy and reconciled, and each Dorm received a cabinet for the storage of liquid medications to improve the availability of medications that were not adequately accommodated by the medication cart. During the Medication Error Committee Meeting, the following initiatives were put forward for consideration and approval by the Committee: • Extend pharmacy hours, • Enlist the help of the Residential Director in articulating expectations for direct care staff to better assist individuals (and nurses) during medication administration, and • Allow the nursing department time to "catch up" to the changes before new interventions are implemented. As of the monitoring review, the above-referenced initiatives were pending further review.	

Recommendations:

1. The facility should develop a plan to address the absence of a Nurse Educator, Nurse Liaison, and Campus Supervisor (M1-M6).

2. The Nursing Department should re-examine its current plan to meet the provisions of Section M of the Settlement Agreement and revise it to ensure that it clearly defines how the department should look, how it should operate, where it needs to go, and how it will get there vis a vis a temporal set of intended actions (M1-M6).

3. The facility should ensure the presence of complete and functioning emergency medical equipment and supplies across the campus and in locations that are immediately accessible in the event of emergency (M1).

4. The current "Use of (Mother-Care) Spoons and Appropriate Cleaning Procedure" should be abandoned in favor of a policy/procedure that appropriately captures the expectation of safe administration of oral medications (M6).

5. Ensure that nursing assessments are accurate, complete, comprehensive and updated when there are significant changes in the individual's health status and/or functioning (M2).

6. Continue to make adjustments in the timetables of the quarterly comprehensive nursing assessments and "QMRP quarterlies" such that the assessments/quarterly reviews overlap (M2).

7. Take steps to ensure that the RN case managers are adequately informed of the expectations for them during the conduct of health risk reviews, i.e., the expectations for them to be adequately informed and prepared prior to the scheduled reviews and the expectations for their active participation in the assessment, review, and planning processes to address individuals' health risks (M5).

8. 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 (M3).

9. 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 (M1, M4, M5).

10. 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, who are often delegated a number of health care duties (M4).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, 2/16/11 o Texas Department of State Health Services, Medication Audit Criteria and Guidelines Revised 4/10 Texas Department of State Health Services, Drug Audit Checklist, Revised April 2010 o EPSSLC Policy and Procedure: Adverse Drug Reaction Reporting, Revised 9/10 o EPSSLC Policy and Procedure: Drug Regimen Reviews, Revised 9/10 o EPSSLC Policy and Procedure: Clozapine Monitoring, 9/10 o EPSSLC Policy and Procedure: Excess/Returned Medications, 9/10 o EPSSLC Policy and Procedure: Prospective Review of New Medication Orders, 9/10 o EPSSLC Policy and Procedure: After Hours Pharmacy, 11/17/10 o EPSSLC Policy and Procedure: Medication Errors, 9/10 o EPSSLC Policy and Procedure: Medication Errors/Incidents, 11/09/09 o EPSSLC Policy and Procedure: Prescribing of Psychoactive Medications, Clinical Monitoring of Psychoactive Medications, 9/10 o EPSSLC Policy and Procedure: After Hours Pharmacy Stock, 9/10 o EPSSLC Policy and Procedure: Pretreatment Sedation Medications, 9/10 o EPSSLC Policy and Procedure: Medication Administration Guidelines, 9/09, rev 3/18/11 o EPSSLC Policy and Procedure: 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, 1/27/11, 2/24/11, 3/31/11, 5/5/11, 5/26/11 o Medication Error Committee Meeting Minutes, 1/26/11,2/22/11,3/22/11,4/19/11,5/24/11 o Polypharmacy Oversight Committee Meeting Minutes, 1/27/11, 2/24/11, 3/31/11, 4/28/11, 5/26/11 o EPSSLC Medication Error Trend Report, FY 2011 and 2011 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #12, Individual #18, Individual #19, Individual #20, Individual #56, Individual #59, Individual #60, Individual #63, Individual #65, Individual #3, Individual #5, Individual #10, Individual #102, Individual #104, Individual #109, Individual #110, Individual #111, Individual #112, Individual #66, Individual #68, Individual #169, Individual #27, Individual #32, Individual #35, Individual #36, Individual #38, Individual #39, Individual #80, Individual #81, Individual #85, Individual #89, Individual #90, Individual #123, Individual #95, Individual #132, Individual #96, Individual #172, Individual #52

	o MOSES and DISCUS forms for the following individuals: • Individual #161, Individual #12, Individual #144, Individual #15, Individual #17, Individual #164 Individual #23, Individual #24, Individual #155, Individual #25, Individual #57, Individual #128, Individual #100, Individual #2, Individual #7, Individual #102, Individual #103, Individual #104, Individual #108, Individual #67, Individual #70 Individual #71, Individual #72, Individual #113, Individual #191, Individual #116, Individual #30, Individual #31, Individual #36 Individual #76 Individual #79, Individual #80, Individual #81, Individual #82, Individual #152, Individual #126 Individual #120, Individual #122, Individual #42, Individual #44, Individual #45, Individual #46, Individual #53 Individual #54 o Single Patient Interventions and Notes Extracts for 14 individuals: o Drug Utilization Evaluation Summaries: • Benztropine and Diphenhydramine • Lamotrigine • Atropine /Benztropine • Proton Pump Inhibitors • Hyperprolactinemia • Hyponatremia • Proton Pump Inhibitors vs. Metoclopramide <u>Interviews and Meetings Held</u>: o Amista Salcido, Pharm.D., Pharmacy Director o Giovanna Villagrann, Pharm.D., Clinical Pharmacist o Ascension Mena, MD, MS, Medical Director o Eugenio Chavez-Rice, MD, Psychiatrist o Denise Jones, APRN, FNP o May Ann Clark, RN, Nursing Operations Officer o Elaine Lichter, RN, Quality Enhancement Nurse o Cynthia Diaz, RN, Nurse Manager o Meeting with Pharmacy Director, Medical Director, Nursing Operations Officer, and QA Nurse <u>Observations Conducted</u>: o Pharmacy Department o Medication Error Committee Meeting o Pharmacy and Therapeutics Committee Meeting o Polypharmacy Oversight Committee Meeting
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated 7/1/11.

	The POI did not actually indicate what activities the facility engaged in to conduct the self assessment. The presentation book contained data on physician interventions and error rates. The POI did not indicate how the self-assessment was used in determining the self-rating. The facility rated itself noncompliant for provision N1, yet it stated that all processes were being completed. It provided no objective data to substantiate the self-rating. Similarly, for provision N6, the facility reported compliance with the requirement for ADR reporting, but rated itself noncompliant. The facility rated itself noncompliant with Provisions N1, N3, N4, N6, N7, and N8. It believed it was in compliance with Provisions N2 and N5. The monitoring team found substantial compliance with item N2. An action plan was included in the POI. This plan included very broad steps in response to the larger provision item. The facility should consider viewing the provision item as a larger goal broken down into objectives, defined by recommendations that require a set of discrete actionable steps.
	Summary of Monitor's Assessment: Continued progress was noted in several areas, while some areas made little progress. The pharmacy continued to document interventions between pharmacists and prescribers. It was not clear if the pharmacists and medical staff were compliant with the requirements for severe drug interactions. Incomplete physician orders appeared to be a problem and notification of the medical staff did not result in any appreciable change in prescribing patterns. The Quarterly Drug Regimen Reviews were thorough and provided the medical providers with good information and reasonable recommendations. The response of the medical staff to recommendations of the QDRRs, and the MOSES and DISCUS evaluations, presented a challenge. Documents frequently showed nothing more than a signature. Adverse drug reaction reporting increased and the data were being used to assess other components of medication practices at the facility. The current policy lacked a threshold for intense review. This was needed to ensure that serious, but non-reportable reactions received appropriate attention. DUEs were completed on a monthly basis, although it appeared that some of these provided little information to the facility. Many steps had been taken to address the problem of medication variances. Numerous systems changes had been implemented. Bin returns decreased and reconciliation rates increased. Even so, significant problems remained such as the overages and shortages associated with the liquid medications. Implementation of systems changes related to liquid refills appeared early on to have an impact on the overage/shortage issue.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>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.</td><td>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.

During an interview with the pharmacy director, it was reported that 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. In cases of severe drug interactions, the pharmacy policy "Prospective Review of New Medication Orders" required forwarding the "Pharmacy Notification of Severe Drug Interaction Order" to the physician for completion. The physician was also required to make a note in the individual's active record regarding the interaction and necessary action. The medication order was held until the physician reviewed the recommendations of the pharmacist and responded in writing.

The monitoring team's document request required submission of copies of all Single Patient Intervention Forms/Pharmacy Interventions since the last monitoring visit. The pharmacy director stated the all forms were not provided since that would have resulted in a massive document generation. Several documents entitled Pharmacy Intervention were provided ranging from February 2011 through June 2011. Examples are summarized in the table below:

<table>
<tr><th>Individual</th><th>Report Date</th><th>Completion Date</th><th>Prescription Problem</th></tr>
<tr><td>99</td><td>4/25/11</td><td>4/25/11</td><td>Formulary</td></tr>
<tr><td>191</td><td>4/25/11</td><td>4/25/11</td><td>Wrong date</td></tr>
<tr><td>109</td><td>4/20/11</td><td>4/20/11</td><td>Incomplete order</td></tr>
<tr><td>82</td><td>4/29/11</td><td>4/29/11</td><td>Formulation</td></tr>
<tr><td>102</td><td>4/20/11</td><td></td><td>Incomplete order</td></tr>
<tr><td>40</td><td>4/20/11</td><td>4/20/11</td><td>Incomplete order</td></tr>
<tr><td>81</td><td>4/20/11</td><td>4/20/11</td><td>Severe DI</td></tr>
<tr><td>36</td><td>4/18/11</td><td>4/20/11</td><td>Incomplete order</td></tr>
<tr><td>14</td><td>5/4/11</td><td>5/4/11</td><td>Formulary</td></tr>
<tr><td>36</td><td>4/11/11</td><td>4/11/11</td><td>Dosing</td></tr>
<tr><td>114</td><td>4/11/11</td><td>4/12/11</td><td>Dosing, Formulary</td></tr>
<tr><td>118</td><td>4/14/11</td><td></td><td>Dosing</td></tr>
<tr><td>79</td><td>4/13/11</td><td>4/14/11</td><td>Unacceptable drug formulation</td></tr>
<tr><td>100</td><td>4/28/11</td><td>4/28/11</td><td>Incomplete order</td></tr>
<tr><td>97</td><td>4/115/11</td><td>4/21/11</td><td>Formulary</td></tr>
<tr><td>8</td><td>5/24/11</td><td>5/24/11</td><td>Wrong drug</td></tr>
<tr><td>184</td><td>5/24/11</td><td>5/24/11</td><td>Formulary</td></tr>
<tr><td>104</td><td>4/29/11</td><td>4/29/11</td><td>Incomplete order</td></tr>
<tr><td>54</td><td>5/23/11</td><td>5/23/11</td><td>Dosing</td></tr>
<tr><td>154</td><td>5/9/11</td><td>5/9/11</td><td>Incomplete order</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

53	5/6/11	5/16/11	Forms
73	5/9/11	5/10/11	Incomplete Rx, Formulary

Although several documents related to severe drug interactions were provided, the drug interaction form was not used. In the case of Individual #81, a Pharmacy Intervention form was completed on 4/20/11 due to a severe drug interaction between quinidine and Saphris. The order for Saphris was written on 4/15/11. The medical provider was contacted and the decision was made to continue therapy and monitor the EKG. A copy of the required drug interaction form was not provided. Upon review of the integrated record, the monitoring team did not find any documentation of this severe interaction. The POI related to this provision item, last updated 8/10, indicated that the drug interaction form was to be used. It did not seem that this process was being completed as required in the agency policy. Following the onsite review, however, the facility gave additional information to the monitoring team regarding a revision of facility policy and procedure expected to occur in September 2011.

The pharmacy director had taken steps to utilize the data generated by the pharmacy intervention forms. The presentation binder contained documents entitled "Prescriber on Pharmacy Intervention Form." This document contained data related to prescribing errors such as allergies, use of wrong drug, incomplete orders, and dosing issues. A total of 3,985 medication orders were recorded with 186 errors, an error rate of 4.67%. Individual providers were notified of their performance through a letter dated 3/7/11. Post intervention data showed a total of 824 medication orders with 39 documented errors and an error rate of 4.73%. The data collection timeframes were not noted. The medical director did not appear to have a specific role in this process. The intervention did not produce any improvement based on follow-up data. Improving physician prescribing patterns should be a continuous collaborative process between the pharmacy director and medical director. The medical director should work with and encourage the medical staff to improve performance in this area. Following the onsite review, the facility submitted some additional information to the monitoring team indicating that the data could show an improvement (2.53% rather than 4.73% if the data for two new providers were removed from the calculation).

Finally, this provision item required the need for review of laboratory testing associated with the use of medications prior to dispensing the medications. In order to achieve compliance with this provision item, the pharmacy will need to have access to laboratory data that is monitored during use of the medications and there will need to be a consensus on the requirements prior to dispensing medications. The pharmacy and medical directors both reported that there was a new contractual agreement with a local laboratory to provide necessary services. It was unclear at the time of the visit how these services would interface with the current system to achieve compliance with the need for

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		a prospective laboratory review. See Recommendations #1 to #5.	
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. The monitoring team was provided copies of 40 of the most recent the Quarterly Drug Regimen Review (QDRR) forms as well as the worksheets used to complete the form. The dates ranged from 3/23/11 to 6/20/11. The QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. Electronic copies and hard copies were provided. Overall, the drug regimen reviews addressed many relevant clinical issues, and provided some good recommendations. The reports included comments, laboratory data, and diagnostic results. Even so, there were a few items that are worthy of additional attention: • In several instances, electronic and hard copies of documents had multiple dates, some were crossed out and replaced with more recent dates. • The DRR policy specified that QDRRs were to be completed every quarter, every 90 days. Although the worksheets indicated that the DRRs were completed quarterly, the dates did not always comply with a 90-day timeframe. • Although the policy required the clinical pharmacist to submit a written report of findings within two days, it did not specify timelines for physician completion. • The recommendations were not always clearly identifiable. This was partially mitigated by the fact that the medical providers received a separate document that contained a chart that summarized the actual recommendations for each individual. The following are some examples of information contained within the QDRRS: <u>Individual #95</u> • Polypharmacy was noted with laxative use and recommendations were made. • Polypharmacy was noted for GERD management and recommendations wee made. • Drug – drug interactions between carbamazepine and simvastatin were documented. The recommendation was made to consider adding an additional drug. <u>Individual #18</u> • The BMD results were documented in addition to the vitamin D level.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• It was noted that the individual was not on bisphosphonates for treatment of osteoporosis and that Prolia should be considered. • Elevated liver enzymes were documented which resulted in discontinuation of the statin. • The individual was on ferrous sulfate and the worksheet contained a comment related to the need for a hematology consult. This was not included as a recommendation and it may have been appropriate to do so. <u>Individual #65</u> • The comments section cited that a comprehensive metabolic panel was needed due to diuretic use. The medication profile did not list any diuretics. <u>Individual #112</u> • The individual was treated for hypertension. Blood pressures were noted to have reached target goals. • Urine microalbumin was not noted in chart as required by the lab matrix. The recommendation was made to obtain this study in addition to obtaining a TSH for monitoring of hypothyroidism and lithium use. <u>Individual #52</u> • Two loop diuretics were used to treat CHF. Comments noted that there was no support for this practice and that the individual was not receiving medical management within practice standards. The individual was not on an ACE inhibitor and no echocardiogram was found in the charts. See Recommendation #6	
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,	The facility implemented a Polypharmacy Oversight Committee. This monthly meeting reviewed many areas of polypharmacy, such as AEDs, antipsychotics, and anti-hypertensives. It also assessed the use of stat mediations and chemical restraints. While the minutes of the meeting presented a great deal of data related to the number of drugs utilized, there was no actual discussion of why individuals who received multiple antipsychotics required those multiple drugs. The use of polypharmacy for antipsychotics was not justified through the use of this process. The use of the new generation antipsychotics and the risk of developing metabolic syndrome were monitored through the Quarterly Drug Regimen Reviews. The facility lab matrix outlined the parameters for monitoring and comments and recommendations were consistently found in the QDDRs reviewed.	Noncompliance

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	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 QDRRs also noted the anticholinergic burden and benzodiazepine use. A DUE was also completed to assess the potential to decrease the anticholinergic burden. The results are discussed in section N7.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	In order to determine compliance with this provision item, the 40 quarterly drug regimen reviews discussed in Provision N2 were assessed to determine the adequacy of the responses from both the primary providers and the psychiatrist: Data related to the primary provider response showed: • 40 of 40 documents included signatures of the primary care provider indicating that review occurred • 10 of 40 documents had dated signatures • 10 of 40 documents noted agreement with the recommendations of the pharmacist • 30 of 40 documents contained no indication of agreement or disagreement with the recommendations of the pharmacist. The psychiatric provider was also required to review the QDRRs: • 36 of 40 documents contained relevant psychiatric information • 36 of 36 included signatures • 10 of 36 had dated signatures • 10 of 36 documents noted agreement with recommendations of the pharmacist • 26 of 36 documents contained no indication of agreement or disagreement with the recommendations of the pharmacist. In May 2011, a space for the date signed was added to the QDRR form which made it possible to note when the document was completed by the pharmacist and reviewed by the physicians. There was no means of determining the timeframes for physician review prior to this change. See Recommendation #6.	Noncompliance
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	A request was made for 40 MOSES and DISCUS tools. Forty-five examples of MOSES and thirty-nine DISCUS evaluations were provided. Forty-five MOSES tools were reviewed. The findings of the documents were: • 2 of 45 (4%) lacked prescriber review (no conclusion, comments, or signature)	Noncompliance

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	MOSES or DISCUS), of tardive dyskinesia.	• 21 of 45 (47%) documented no conclusion by the prescriber • 10 of 45 (22%) documented no action necessary by the prescriber • 6 of 45 (13%) provided specific medication changes Thirty-nine DISCUS evaluations were reviewed and showed that: • 2 of 39 (5%) lacked prescriber evaluation (no conclusion, comments, signature) • 14 of 39 (36%) lacked a prescriber conclusion • 25 of 39 (64%) indicated TD was absent • 29 of 39 (65%)had an evaluation completed in the previous quarter The MOSES evaluation was to be completed every six months while the DISCUS evaluation was required every three months. Completion of these documents by nursing and medical services proved to be problematic. A series of seven email exchanges between the clinical pharmacist and nursing services documented 43 individuals who had either outstanding MOSES or DISCUS assessments. The dates of the emails spanned from 5/16/11 to 7/8/11. On 5/16/11, the nursing operations officer indicated that the case managers on the Dorms unit had not received training on completion of the assessments. Over 50% of the MOSES evaluations were either not reviewed by the prescriber or were signed, but contained no other evidence that the information was considered. The DISCUS evaluations were not completed quarterly for 35% of the documents reviewed. Additionally, 41% of the evaluations were either not signed or contained no provider conclusions. The evaluations were either signed by the primary provider or the psychiatry provider. All of the documents reviewed and signed by the psychiatrist were appropriately completed and contained the necessary conclusions. <u>Additional Discussion</u> The MOSES and DISCUS assessments are intended to identify the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia respectively. The information gleaned from these evaluations is worthy of more than a cursory review by the medical staff. This information also has relevance in the assessment and treatment of neurological and seizure disorders and as such should be provided to the neurologist for consideration in the treatment planning. DUEs discussed in Provision N7 also indicated that compliance with completion of these evaluations was somewhat problematic. The facility's POI documented that effective 5/1/11, notifications were sent on a quarterly basis informing case managers of outstanding MOSES and DISCUS evaluations.	

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		See Recommendations #7 to #8.	
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 implemented a new ADR protocol in September 2010. ADRs were reviewed and discussed in the Pharmacy and Therapeutics Committee meetings. Thirty seven adverse drug reactions were reported from December 2010 to May 2011: • 5 of 37 were related to elevated prolactin levels • 4 of 37 were related to hyponatremia • 3 of 37 were related to thrombocytopenia • 3 of 37 were related to EPS It appeared that these data were being utilized to review safe medication practices at the facility. For example, although the reporting program was in its infancy, it was noted that several reactions were related to elevated prolactin levels and hyponatremia. This resulted in further scrutiny using the existing drug utilization evaluation process and this was good to see. Fourteen of the reactions were reported as moderate and 23 were mild. Based on the agency's current policy, a moderate reaction involved was one in which: • The ADR required suspected drug be withheld • No antidote or other treatment was required • The ADR required hospitalization The current form did not specify if all three criteria needed to be met to achieve a severity rating of moderate. This was important as the mild ADR definition also stated that the ADR required no change in treatment with suspected drug and did not require the drug be held discontinued or changed. <u>Additional Discussion</u> While there is no definitive severity scale, it is important that the agency set a threshold for taking additional actions based on the severity of the ADR. This would include a requirement to conduct an intense case analysis or other detailed analysis of the reaction based on the severity of the reaction. For example, a moderate ADR could result in hospitalization. Any ADR resulting in hospitalization should prompt the medical director and pharmacy director to formally conduct a more detailed analysis of the event. The ultimate goal is to prevent future occurrences. See Recommendation #9	Noncompliance

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N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility completed a new DUE calendar in October 2010 and implemented reviews. Six DUEs were completed from January 2011 to May 2011. There was no written procedure to guide this process. The pharmacy director reported that one DUE was completed each month. DUE reports included background data, results, and recommendations. The objectives, results, and recommendations included in the reports are summarized below: <u>Benztropine and Diphenhydramine</u> • Objective - The objective was to identify individuals who were on both drugs with a recommendation to discontinue one agent due to a lack of literature supporting the safety and efficacy of dual use in the treatment of EPS. • Results and Recommendations – There were no individuals on benztropine and diphenhydramine. Recommend to continue to monitor for side effects. <u>Lamotrigine</u> • Objective - The objective was to identify individuals on lamotrigine therapy and provide appropriate recommendations when meningitis risk is highest. This DUE was in response to an FDA warning alert about the risk of aseptic meningitis with the use of lamotrigine. • Results and Recommendations - There were no individuals who had been started on lamotrigine during the three months prior to the DUE. Reported that risk has great within the first three months of therapy. Monitoring of individuals started on lamotrigine and updating of lab matrix. <u>Atropine /Benztropine</u> • Objective – The objective was to identify individuals taking tablets and assess the anticholinergic side effects in those who had already switched to sublingual drops. Sublingual eye drops was an available alternative to current tablet therapy. • Results and Recommendations - Four individuals were identified who were candidates for sublingual atropine. The recommendation was to find alternative therapies in order to decrease side effects. <u>Protein Pump Inhibitors</u> • Objective – The objective was to identify individuals who were on long term PPI therapy due to the FDA safety announcement of the risk of low magnesium levels associated with long term use of PPIs. • Results and Recommendations – 78 individuals were identified as receiving treatment with PPIs. Fifty-nine of the individuals received the drugs for longer than one year. The lab matrix was updated to include PPI monitoring.	Noncompliance

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		Hyperprolactinemia • Objective - The objective was to identify those individuals at risk for antipsychotic induced hyperprolactinemia, evaluate current monitoring and establish appropriate monitoring parameters to prevent additional adverse drug reactions. This was a response to four ADRs reported for hyperprolactinemia • Results and Recommendations - Twelve individuals were identified who received the drugs haloperidol, chlorpromazine, thioridazine, risperidone and Iloperidone. Three individuals received risperidone and Iloperidone had appropriate monitoring of prolactin. Three of twelve individuals receiving other drugs had appropriate monitoring of prolactin. The prolactin in one of these individuals was elevated. The drug matrix will be updated. Hyponatremia • Objective - The objective was to identify individuals at risk for hyponatremia and evaluate current monitoring per the lab matrix form to prevent additional adverse drug reactions. The DUE was in response to three adverse drug reactions reported associated with the use of carbamazepine and Oxcarbazepine. • Results and Recommendations – Thirty one individuals were identified who received these drugs. --Seventeen individuals received carbamazepine: o 17 of 17 individuals had appropriate eye exams o 10 of 17 persons had plasma level monitoring o 12 of 17 has appropriate lab monitoring o 15 of 17 had appropriate completion of MOSES --Fourteen individuals received Oxcarbazepine: o 9 of 14 individuals had appropriate CMP monitoring o 12 of 14 individuals had Appropriate LFT monitoring o 12 of 14 individuals had appropriate MOSES completion. Proton Pump Inhibitors vs. Metoclopramide • The objective was to identify individuals who were on PPIs and/or metoclopramide with the corresponding indications. Available literature will be reviewed to evaluate the role of these agents in treatment for GERD. • Results and Recommendations – i. 82 individuals were on PPIs ii. 13 individuals were on Reglan iii. 11 of 13 individuals were on PPI and Reglan Recommendations were given for given for continued monitoring.	

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		A summary report in a standardized format was provided for each DUE completed. Notwithstanding a standardized report format, the monitoring team noted that the following aspects of the DUE process and report require attention: 1. The recommendation section combined a great deal of educational information combined with the recommendations. As a result of this, it was difficult to actually tease out the recommendations. 2. There was no specific corrective action plan and the P&T minutes did not provide any specific details on the corrective actions. The need for a definite plan based on the recommendations is of particular importance to ensure that information gleaned and recommendations generated are actually implemented and followed up. A correction action plan should be generated for each DUE that results in recommendations. 3. The process and outcome criteria were not always clearly identified. This is necessary in order to establish a baseline and complete follow-up assessments. The facility did not have a formal policy related to the DUE process. The pharmacy director reported that one DUE was being completed each month. The exact rationale for choosing the drugs was not clear. The first DUE was completed for a drug regimen that was not received by any individuals at the facility. While the objective of moving to monotherapy is an important one, the facility could have quickly identified that there were no individuals receiving this drug combination. The second DUE related to Lamotrigine also resulted in little information for the facility since no individuals were identified who were within the most critical timeframe. These issues could likely be prevented if the DUE process specified the exactly methodology for the process such as how the population under study was to be chosen. If there are no individuals that the criteria apply to, will likely not impact the medication use system of the facility but would serve as a source of information. See Recommendation #10.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility maintained a system for tracking medication variances. Medication variances were reviewed by the Medication Error Review Committee as well as by the Pharmacy and Therapeutics Committee. Over the past several months, many processes were changed and some new processes implemented including: • Medication pass times were changed in order to standardize med passes in homes. • New laminated photographs of individuals were placed in MARs to assist with identification of individuals. • The new medication administration policy required direct care professionals to	Noncompliance

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		participate in medication administration passes. Multiple data sets were provided to the monitoring team. Some of the data provided were not usable since individual pages had dates blacked out and there was no way to determine the data collection period. This also applied to several graphs that lacked data collection timeframes. Data taken from trend reports is summarized below.	

Medication Errors Sep 2010 – June 2011										
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Number of meds returned to pharmacy	205	356	544	--	293	299	--	211	--	--
Bin/Omission	98	29	52	39	90	48	16	33	2	0
Omissions	41	76	84	111	71	60	47	79	85	68
Total Errors	160	140	166	164	192	131	101	128	115	90

It was clear that the changes had impacted the number of variances occurring in the facility. Bin omissions had decreased significantly as well as total errors. Even so, there were other problems noted. During the January 2011 review, the monitoring team questioned the reconciliation of liquid medications. In response to this, the pharmacy director began looking into liquid medication reconciliation and reported that liquid medications counts did not appear correct. In fact, multiple bottles of excess medications were being discovered. These finding were documented in MERC and P&T meeting minutes. This would indicate that either the medication was not being given or that medication was being borrowed. Both were unacceptable practices. In recent weeks, new processes related to refilling were implemented by the pharmacy department and the problem appeared to be diminishing somewhat. The discrepancies in the amounts of liquid medications were not captured in the medication errors reported.

Omissions remained challenging for the facility. Each omission represented an episode in which the individual did not receive a prescribed medication and, therefore, there was great cause for concern. There were plans to provide additional support to the direct care nurses, complete more observations and map out the medication administration process in an effort to improve in this area.

An additional concern related to medication errors was the reporting process. Pharmacy intervention data indicated several issues related to medical staff prescribing, including incomplete orders, wrong drug, and wrong drug dose. Those issues did not appear to be captured in the medication error data. The pharmacy director reported the problems were essentially intercepted and, therefore, not errors. The pharmacy director should carefully review data to ensure that all errors that occur within the medication use

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		system are appropriately reported. See Recommendation #11 to #12.	

Recommendations:

1. The pharmacy must document all interactions between the pharmacists and the clinicians. The pharmacy director must ensure compliance with the process for managing potential severe drug interactions (N1).

2. Pharmacy intervention data should be consistently collected, analyzed and provided to the medical director who should when necessary counsel the medical staff on performance issues (N1).

3. The medical director should work collaboratively with the pharmacy director to develop education programs for the medical staff related to safe medication practices and medication errors (N1).

4. The facility will need to determine how to provide the pharmacy with access to laboratory information since the need for laboratory testing must be considered as part of the prospective review (N1).

5. The medical director and pharmacy department will need to determine what drugs require lab monitoring and prioritize which will be included in the prospective review (N1).

6. The following concerns related to the Quarterly Drug Regimen Reviews should be addressed (N2, N4):
    a. The pharmacy director should ensure that the QDRRs meet the requirements for quarterly review, every 90 days.
    b. The dates of documents should be precise and clear. Strikethroughs should only occur when absolutely necessary.
    c. The medical director should ensure that medical providers are appropriately completing QDDRS. The reviews should be signed, dated and agreement or disagreement noted. When disagreement is noted, an entry should be made in the IPN regarding the rational for the disagreement.
    d. The QDRR policy should be revised to provide a specific timeframe for review and returns of the QDDR by the medical staff.
    e. Compliance with the requirements for timely and adequate completion of the QDRRS should be monitored by the Quality Enhancement Department.

7. The medical director should work with the chief nurse executive to ensure that the MOSES and DISCUS evaluations are being completed in a timely manner (N5).

8. The medical director should provide guidance to the medical staff on the requirements for physician review and completion of the MOSES and DISCUS assessments (N5).

9. The ADR policy should be revised to include a threshold for intense case analysis. One requirement should be that any ADR associated with hospitalization require an intense case analysis or review of the circumstances surrounding the adverse event. When deficiencies are noted, a corrective action plan should be developed that provides action steps, responsible persons, and timelines for completion (N6).

10. A policy for completion of DUEs should be developed. It should specify requirements for completion, such as determination of calendar, drugs for review, and sample size selection. It should also specify requirements for corrective action plans such as the specification of action steps, responsible parties and timelines (N7).

11. The nursing department should increase its efforts to determine the causes of the errors of omission. The task of mapping out the process of medication administration should be completed. This information should be used to determine process gaps, faulty processes, and other issues that may be contributing to the problem (N8).

12. The pharmacy director must ensure that all medication errors are captured and reported. These data should include actual medication errors that occur in the prescribing phase of the medication use system. These data should be used for counseling the medical staff as well as development of educational programs (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **<u>Documents Reviewed</u>:** o PNMT member list o CVs/resumes for PNMT members o PNMT Continuing Education documentation o Section O Presentation Book and POI o Current Census By Home o Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management o PNM Needs list o PNMT meeting minutes and sign in sheets o PNMT Evaluation template o PNMT Evaluations for Individual #97, Individual #93, Individual #115, Individual #113, Individual #84, Individual #191 o PNMT Background Documentation packets for Individual #84, Individual #115, Individual #113, Individual #93, Individual #97 o Aspiration Pneumonia/Enteral Nutrition Assessments for Individual #71, Individual #103, Individual #155, Individual #92, Individual #10, Individual #18, Individual #178, Individual #59, Individual #191, Individual #1 o List of hospitalizations/ER visits o PNM Monitoring form template o Requested of Observed Monitoring Form template o Completed PNMP Monitoring Forms submitted o Completed Mealtime Monitoring Forms submitted o PNMP monitoring spreadsheets o Documentation from monthly PNMP monitoring meetings (November 2010 to April 2011) o NEO training curriculum for PNM o PNMPs submitted o Sample Dining Plans and Inservice training sheets submitted o List of individuals with MBSS and Clinical Dysphagia Evaluations o PNM Maintenance Log o Work Order Spreadsheet o PNM spreadsheets o OT Assistive Equipment List o PNMP Assistive Equipment List o Risk Level Rating of High

	o Risk Level Rating of Medium o High Risk POI Information as of 6/15/11 o List of individuals with enteral nutrition o Individuals with BMI greater than 30 o Individuals with BMI less than 20 o List of individuals with 10% unexplained weight loss in six months o Individuals who require mealtime assistance o List of individuals with modified diet textures/ liquids consistencies o Food Textures/Liquid Consistency Downgrades o Clinical Dysphagia Evaluation for Individual #39 (6/2/11) o Decubitus Ulcer Record 2011 o Injuries Fracture- Suture-Dermabond (12/1/10 – 5/30/11) o Falls Incidents 12/1/10 – 5/30/11 o Total Pneumonias (9/1/10 - 6/17/11) o Individuals who were non-ambulatory or assisted ambulation o Individuals with Primary Mobility Wheelchair o Individuals who Use Transport Chairs o Individuals with Orthopedic Devices and Braces o Ambulation Assistive Devices – Gait Belts o Individuals who require assisted ambulation o Individuals who were non-ambulatory o Information from the Active Record including: Personal focus Assessments, PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, Annual Medical Summary and Physical, Active Problem List, Hospital Summaries, GI Consults, Orthopedic consults, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab I included Communication assessments and updates), Nutrition tab and PNMP tab for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o PNMP section in Individual Notebooks (included communication books and dictionaries) for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o Mealtime Observation/PNMP monitoring sheets for last six months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual

	#93, Individual #115, Individual #1, Individual #21, and Individual #8. o Assessments, SPOs, and other documentation related to speech treatment for Individual #56, Individual #63, Individual #50, Individual #39 and Individual #172. Interviews and Meetings Held: o Anderson Hicks, OTR Habilitation Therapies Director o PNMT members o Therapy Technicians o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Programs o NEO training o PSP meeting for Individual #2 o PNMT meeting for Individual #191
	Facility Self-Assessment: EPSSLC submitted its self-assessment for this provision (POI), updated on 7/1/11. In addition, the monitoring team requested that the Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements or the status of a variety of tasks since the previous review in January 2011. The correlation of these tasks to each provision item was not always clear. Also, there was no mechanism to determine how the facility had determined noncompliance with each item in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management Guidelines self-audit tool was included in the Presentation Book but no completed audits or analyses of audits completed in the last six months were included. A list of Action Steps were included in the POI, but were not related to a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. Only one of the 24 action steps listed were completed and one had not been initiated to date. The action step to hire an RN for the PNMT had a projected completion date of 6/1/11, but was still in process. This approach appeared to merely document completion of tasks rather than to serve as clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be shorter-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps.

	Example action steps stated: • Review of all individuals that are provided nutrition and hydration via a tube, to determine if it is medically necessary, shall be completed by the PNMT members (completion date 12/31/11). • Provide competency-based NEO and Block Refresher PNMP training for designated staff (12/31/11 completion date) These were essentially redundant statements from the Settlement Agreement and did not offer any specific steps or actions to make that happen. The monitoring team concurs with EPSSLC self-assessment of noncompliance for each of the elements in Provision O.
	Summary of Monitor's Assessment: The PNMT at EPSSLC was not a fully constituted team at the time of this review. Alternate nursing participation had been accomplished via attendance at the meetings by a variety of RN Case Managers to date. The other team members were not, and could not be, dedicated team members given the current staffing levels for OT, PT, SLPs, and part time dietitians. The PNMT had previously struggled with their dual role as clinical PST member and PNMT member as an adjunct to the PST rather than a substitute for the PST. This continued to be an issue as demonstrated by the meeting conducted during this onsite visit. Though the PNMT had been encouraged during the previous review to be more proactive in identifying individuals who would benefit from PNMT assessment, only five individuals had been assessed since October 2010. There had been no new evaluations initiated since January 2011 until the review for Individual #191 initiated during this week. The PNMT conducted no systems review of individuals who had been hospitalized or identified with high risk indicators who may have required PNMT review and intervention. The redundancy of their roles on the PNMT and the PST was understandably confusing and they would benefit from consultative support in this regard. Documentation of the PNMT meetings showed that the discussion was largely anecdotal rather than data-driven and action oriented. It would be difficult for anyone to track data collected, clearly identify the clinical reasoning process used by the team, recognize specific actions planned, or taken or to determine if interventions were effective to mitigate the presenting concerns that required PNMT assessment and review in the first place. Of significant concern was the status of PNM staff training specifically related to mealtime. This training was observed during this week. The training by professional staff was poorly presented. Content and handouts were not meaningful or functional for direct support staff in their role of providing PNM supports. While some improvements were noted in the Dorm area during mealtimes, the NEO training did not provide a solid foundation upon which to build knowledge and skills for individual-specific training of Dining Plans. Further, staff were not confident in their understanding of why specific supports were needed and individual risks indicators of the individuals for whom they were responsible. The current

	training must be immediately abandoned for a well-designed curriculum with appropriate content, instructional methods, and materials. There continued to be concerns with the lack of repositioning before meals and staff implementation of mealtime supports in 513 continued to be problematic as noted in every previous onsite review. There was no self-correcting system in place to address the issues noted in this home and, thus, the same errors continued to occur and re-occur. Overall progress toward substantial compliance with this element was disappointing. On several counts the accuracy of information provided to the monitoring team by the Habilitation Therapies Director was questionable. Clearly any progress made to date was by virtue of the therapy clinicians themselves and not to any direction or strategic planning from him. There were no directed initiatives. There were very strong, hard working PNM clinicians at EPSSLC and for the most part, they appeared to work well together. There were several outstanding highlights noted and included: • Karin De La Fuentes had worked with the PSTs to review individuals with regard to enteral nutrition and a number of these were currently progressing with the successful transition to oral intake. • The monitoring team's previous concerns for Individual #93 related to position, alignment, and support during meals had been addressed and she appeared to be more optimally aligned, and appeared to be more calm and less stressed during meals. Staff observed on two occasions were doing a great job with implementing a better designed Dining Plan for her. • There were fewer errors in the provision of diet texture and liquid consistency, particularly in the Dorm area. The response to the document request for this provision was not well-organized and in many cases the information requested was not provided and/or a tremendous amount of unrelated documents were submitted. It did not reflect well on the department. Lack of attention to this aspect of the process toward achievement of substantial compliance is a missed opportunity to address the quality of work products and should not merely be seen as a paper chase exercise. Following this onsite visit, EPSSLC received a letter from DOJ regarding concerns identified by the monitoring team. In response, a plan was developed by DADS to immediately assess and intervene by providing mentoring, training and develop an action plan to improve the performance in the provision of PNM supports and services. This much needed plan was reviewed by the monitoring team and was determined to be appropriate, though the plan was not anticipated to be finalized by DADS until the 8/31/11. It was recognized that a number of these activities were already in place or planned for the near future and were not merely in reaction to issues identified during this review. It would be anticipated that with these steps, more significant progress will be noted in the subsequent monitoring team review in January 2012. Interim updates in this regard would be anticipated as well.

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01	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional 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,	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** EPSSLC formally initiated the new process for the Physical Nutritional Management Team (PNMT) in October 2010. At that time there was no identified nurse or OT member serving on the team, there was no chairperson assigned to this team, and there had not been a nurse permanently assigned. Per the POI, this position was posted in late April 2011 Mary Clark, RN, was the candidate selected by the habilitation services director due to her experience. She was, however, acting as the chief nursing executive at the time of this review. It was reported that when the CNE returned, Ms. Clark would be permanently assigned to the team. Ms. Clark reported to the monitoring team that she attended the meetings when she could. Adjunct members included the QMRPs, nurse case managers, psychology, home managers, direct support staff, and other PST members for the individuals reviewed during the PNMT meeting. Evidence of current licenses was not submitted for the clinicians listed, other than for the PT and OT. The resumes/CVs submitted for the nurse, PT, SLP and dental hygienist indicated that each of these clinicians had at least three years of experience with individuals who had developmental disabilities. This was not documented in the resume for the dietitian. There was no resume submitted for Mr. Gardea the OTR on the team; he was a new graduate and his license had been issued on 4/7/11. Continuing education documented since the previous review included state-sponsored webinars on 1/18/11 and 1/20/11. The POI reported that therapists had attended a dysphagia workshop on 4/8/11, though evidence of attendance by core team members was not submitted. There were 32 meetings documented (however, see below for the monitoring team's comments on these meetings). Attendance by the core team members was as follows: • PT: 18 of 30 • SLP: 26 of 30 • RN: 6 of 26, Ms. Clark also attended three of the meetings • RD: 19 of 30 • RDH: 15 of 30 • OT: 8 of 30 Alternate professionals attended some of the meetings in addition to, or instead of, a core	Noncompliance

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	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.	team clinician. There were some instances however when there was no representation by each discipline as follows: PT (3), SLP (3), RD (4), OT (16, though three of these were attended by Mario Gardea prior to licensure), RN (5), and RDH (16). A dental hygienist (RDH), though identified in the Presentation Book as a core team member, was not listed as such on the sign in sheets submitted. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The PNMT met to assess and review individuals at risk for PNM concerns. Meetings were documented in PNMT review notes. Initial assessments were completed using the PNMT Evaluation form. Each team member was responsible to contribute information to the assessment. Subsequent reviews were scheduled by the team at each meeting. PNMT assessments since October 2010 to April 2011, per the Presentation Book, included the following: • Individual #93, Individual #84, Individual #115, Individual #113, Individual #97. Though not listed in the presentation book, documentation related to PNMT meetings was submitted for Individual #84. The PNMT met regarding Individual #191 during the week of this onsite review and, by report, this was the first meeting for him. The monitoring team attended this meeting and requested and received the draft of his PNMT evaluation (undated). The monitoring team requested minutes, including documentation of attendance, for all PNMT meetings. The documents submitted were disorganized and duplicate documentation was submitted for various requests. With much effort, the monitoring team was able to piece together the following list of meetings based on the documentation (sign-in sheets and minutes) submitted: • Individual #115: 1/13/11, 1/20/11, 2/17/11, 3/3/11, 4/5/11, 4/14/11, 5/3/11. • Individual #97: 11/9/10 (no minutes), 11/12/10, 11/23/10, 11/20/10, 12/9/10, 12/21/10, 1/13/11, 1/20/11, 2/10/11, 3/24/11, 4/28/11, 5/3/11. • Individual #84: 11/4/10, 11/9/10, 11/16/10, 11/18/10, 11/30/10, 12/7/10, 12/16/10, 1/6/11, 1/20/11, 2/1/11, 3/1/11. • Individual #113: 1/27/11, 2/10/11, 2/24/11, 3/3/11, 3/24/11. • Individual #93: 10/28/10 (no minutes), 11/2/10 (no minutes), 11/16/10, 12/7/10, 12/21/10, 1/25/11, 2/8/11, and 2/24/11 (no minutes). • Individual #97: 11/9/10 (initial), 11/12/10, 11/23/10. • Individual #84: 11/10/10. • Individual #115: 1/6/11.	

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		Thus, based on this gathering of documents, there appeared to be 32 meetings held, with 16 of them conducted since the previous onsite review. No meetings had been conducted since 5/3/11 until the week of the current review and, as stated above, the monitoring team attended on 7/12/11. PNMT assessments were submitted for Individual #115 (1/6/11), Individual #84 (first page was missing), Individual #93 (10/28/10), and Individual #97 (11/12/10). No PNMT assessment was submitted for Individual #113. No action plans were submitted based on the format developed by the State. In general, although these were called PNMT meetings, they did not meet the standard that one would expect in terms of content, agenda, and breadth of discussion. Further, the meeting documentation indicated discussion that was often anecdotal rather than data driven. Some examples included: • Individual #115 (1/13/11): The SLP "says that he was under the impression that since December he has been doing a lot better" and the RD "says that last year at this time he was above his ideal body weight, but has since lost weight and is now back on track." • Individual #84 (2/1/11): The psychologist "reports that according to the data, after the 20th there weren't that many incidents of SIB" and "when she has seen him fall it's for different reasons, not just one thing." • Individual #113 (2/10/11): The SLP "thinks he could benefit from breathing treatments" and "the facility should hire a respiratory therapist." Further, the meeting minutes were in different formats and seemed to be a function of who was taking notes. The following summary of the sequence of meetings held for Individual #113 illustrates the lack of organization, direction and focus of the PNMT at EPSSLC: • There was no PNMT assessment submitted. • 1/27/11: Attended by core team members including the SLP, RD, OT, and RN (other than Ms. Clark). The reason for referral was not stated in the meeting minutes. A different nurse than the one attending was to have developed a form to track emesis and she was not present. It was documented that behavior issues could not be discussed because the psychologist was not present. There were five recommendations to be completed by the next meeting on 2/10/11. No measurable outcomes were established for Individual #113. • 2/10/11: Attended by core team members including the PT, SLP, RD, OT, and RDH. Only 1 of 5 recommendations from the previous meeting were completed at that time. It was reported that "nursing tried to pass suctioning to DCS; DCS not suctioning." The only recommendation was to "pursue Doctor for respiratory	

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		therapy." • 2/24/11: Attended by core team members including PT, OT, RN (other than Ms. Clark), and RDH. There were 5 of 6 recommendations from the previous two meetings still incomplete. • 3/3/11: Attended by core team members including the SLP, RD, OT, and RN (other than Ms. Clark). The documentation indicated that a recommendation for a second GI opinion was not needed, per physician; a recommendation for an endocrinology consult was not needed due to two previous consults, also per physician; and a recommendation for tracking emesis was still not implemented. A document labeled "Vicky's Notes" reported that emesis was being tracked, but that the nurse was not aware of any current episodes even though emesis was the reason he was referred to the PNMT in the first place. Previous recommendations related to a respiratory therapist and positioning in bed and recliner were not addressed. • 3/24/11: Core team members in attendance included the PT, SLP, RD, and RN (other than Ms. Clark). No follow-up on bed or recliner positioning had occurred. No follow-up as to whether actions related to the wheelchair were effective had occurred. Individual #113 was referred to a pulmonologist, though there were still no data presented that supported that recommendation. It was reported that since the "third" there had not been any episodes of emesis and that he had never gone this long without emesis. The PNMT discharged Individual #113 back to the PST. There was no summary of actions taken. There was no evidence that the reason for emesis had been identified and as such what interventions had been taken or were effective. There was no action plan developed for the PST and discussion of training or monitoring required. There was no review of his health status or risk indicators. One of the purposes of this group was to identify supports, services, or interventions to address issues related to referral to the PNMT or other concerns noted via comprehensive assessment. It would be critical to carefully track all issues through to completion with thorough documentation of findings. The PNMT was not functioning properly.	
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	**Standard: A process is in place that identifies individuals with PNM concerns.** Per a list submitted for this onsite review, there were 131 individuals identified with PNM needs at EPSSLC, that is, 100% of the current census (131). Each of these was provided a PNMP. A new policy and process used to establish health risk levels had recently been implemented statewide in January 2011. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this review, the teams were working to integrate this into the new PSP process initiated in the Fall 2010. The PSTs will require	Noncompliance

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	difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	ongoing clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. Meetings related to the risk assessment process with one PST was conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. The statewide system to identify and manage individuals at risk was outlined in policy #006.1, At Risk Individuals, and included the statement that the PNMT was "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…" 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 monitoring team discussed with the PNMT at EPSSLC that as these processes were evolving, it would be necessary to proactively identify individuals who may benefit from PNMT assessment. For example, one individual was recommended for review by the monitoring team at that time resulting in assessment and follow-up by the PNMT (Individual #115). Surprisingly, there were no referrals to the PNMT, nor was any individual identified with a need for assessment until the week scheduled for the monitoring team's onsite visit (Individual #191) at which time, his initial meeting was held. There were a number of individuals with multiple PNM-related risk factors or issues who potentially would benefit from the coordinated, comprehensive supports and services of the PNMT. The monitoring team is providing this level of detail in hopes that it will help the facility to attend to their risks and PNM needs. • There were 131 (100% of the current census) individuals identified with PNM needs and were provided a PNMP. • There were 51 (39%) individuals with poor oral hygiene in the last six months. Three of these individuals were diagnosed with aspiration pneumonia from 9/1/10 to 6/17/10 (Individual #1, Individual #21 and Individual #8). • There were 10 (8%) individuals with 14 incidences of skin breakdown in the past year. Five of these were listed as unresolved per the documentation submitted (Individual #191, 3 sites; Individual #178 and Individual #111). • There were eight (6%) individuals whose diet had been downgraded in the last	

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		year. • There were 19 (15%) individuals who were obese with BMIs 30 or over and considered to be obese with 2 of these with a BMI over 40. • There were 21 (16%) individuals with a BMI less than 20, with 12 of these with a BMI under 18.5 (underweight). • There were three (2%) individuals with unplanned weight loss (Individual #67, Individual #195 and Individual #93). These individuals had lost more than 10% of their weight in six months' time. Individual #44 was listed with 100% weight loss in 180 days, presumed to be an error. • Per documentation submitted there were no choking events investigated in the last 12 months. There were six (5%) individuals listed as HIGH risk for choking and 16 individuals (12%) listed at MEDIUM risk for choking. • There were 41 (52%) individuals who required assistance at mealtime. • There were 101 (77%) individuals with modified diet textures and 13 (9%) with thickened liquids. At least 25 individual's diet texture had been downgraded in the last 12 months. • There were 11 (8%) individuals who were enterally nourished per the diet list submitted and 14 (11%) per the list submitted for VI.2.U. A third list identified 12 individuals (9%) who received nourishment via tube. Two of these individuals were diagnosed with two cases each of pneumonia in the last year (Individual #1 and Individual #97). • There were approximately four (3%) individuals with six incidences of pneumonia between 9/1/10 and 6/17/11. Three of these were identified as aspiration pneumonia (Individual #21, Individual #8, and Individual #1). Individual #97 was listed with two incidences of bacterial pneumonia and Individual #1 with one. There were 11 (8%) individuals listed at HIGH risk for aspiration. Of those with pneumonia, only Individual #8 was identified at HIGH risk. There were 12 individuals (9%) listed at MEDIUM risk for aspiration. Individual #97 was identified at MEDIUM risk. Neither Individual #21 nor Individual #1 were identified with any risk of aspiration. • There were 51 (39 %) individuals identified as non-ambulatory or requiring assistance for ambulation. • There were 39 (30%) individuals who used a wheelchair as a primary means of mobility. • There were 56 (43%) individuals who used assistive equipment for ambulation including gait belts. • There were 24 (18%) individuals who used transport wheelchairs as needed. • There were 37 (28%) individuals with upper or lower extremity orthotics. • There were approximately 10 (8%) individuals who had experienced approximately 13 falls with injury in the last year. Though total fall data had been	

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		requested, this information was not submitted. Interestingly, Individual #75 (12/11/10) and Individual #66 (12/27/10) were listed with fractures due to a slip, trip or fall but were not listed with a fall with injury on the Fall Incidents list. • There were six (5%) individuals who sustained an injury resulting in a fracture in the last year. Two of these individuals used a wheelchair as their primary means of mobility per the list provided (Individual #66 and Individual #154). Two others were injured in a slip, trip or fall who used a wheelchair as their primary means of mobility. • There were nine (7%) individuals listed at HIGH risk for osteoporosis. There were 10 (8%) others listed with a MEDIUM risk for osteoporosis. • There were 18 ((14%) individuals admitted to the hospital since 5/3/11, most of whom had PNM-related issues or diagnoses. The complexity of PNM-related risk indicators requires comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The current system of risk identification continued to be problematic.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**Standard: All persons identified as being at risk and requiring PNM supports are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).** As stated above, there were approximately 131 individuals identified with PNM needs and all (100%) had PNMPs. The PNMPs were generally of a consistent format and contained information related to the focus, risks, assistive equipment, mobility, transfers, movement techniques, positioning (bed, wheelchair, alternate), positioning schedule, bathing, dining plan, dining equipment, food texture, allergies and communication strategies. There were 51 individuals with poor oral hygiene. • Only a plan for Individual #93 dated 5/27/11 minimally addressed oral care. The instructions were limited only to her being seated in her wheelchair and remaining there for one hour after. There were no instructions related to head position or support, thickened liquids or other precautions and special techniques. • There were six individuals listed at HIGH risk for choking and 16 at MEDIUM risk. There were 11 to 14 individuals who were enterally nourished, two of whom had pneumonia in the last year. There were two others who ate orally and had aspiration pneumonia in the last year. There were 11 individuals identified at HIGH risk for aspiration and 12 at MEDIUM risk. There were 13 who were provided thickened liquids. At least 25 individuals' diet texture had been downgraded in the last 12 months. Each of these individuals would likely benefit from specialized instructions or precautions related to oral care.	Noncompliance

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		All of the individuals described above who would benefit from oral care instructions in their PNMP also likely required instructions related to positioning, texture, liquid assistance, swallowing precautions, and/or special presentation techniques or utensils. This was not noted in any of the PNMPs. An entry dated 6/20/11 in the POI for this provision reported that Habilitation Therapies had met with the pharmacist regarding individuals who received a modified diet (101) or liquid consistency (13) to determine the most appropriate texture/consistency of prescribed medications and safe positioning. It was stated that this would be added to the MARs. There was no evidence that this meeting had included nursing or that this action had been completed. By report, the PNMPs were included in the MARS at that time. The monitoring team selected 15 individuals for a record sample for a review of PNMPs (included in the above list of documents reviewed). Additionally, PNMPs for three other individuals reviewed to date by the PNMT were included as well (Individual #97, Individual #84, Individual #113). The PNMPs submitted for each of these 18 individuals were reviewed with findings below. These are provided in great detail in hopes that the information will be useful to the facility: • PNMPs were submitted for 18 of18 (100%) individuals included in the sample. • PNMPs for 18 of 18 individuals in the sample (100%) were current within the last 12 months. • In 15 of 18 of PNMPs reviewed (83%), the staffing listed was current within the last 12 months. • In 18 of 18 PNMPs reviewed (100%), positioning was addressed. • In 6 of 11 PNMPs reviewed (55%) for individuals who used a wheelchair as their primary mobility, included some positioning instructions for the wheelchair. • In 18 of 18 PNMPs reviewed (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 15 of 18 PNMPs reviewed (83%), the PNMP listed bathing instructions and listed equipment when needed. In 4 of 18 PNMPs reviewed (24%), toileting instructions were identified. • In 17 of 18 PNMPs reviewed (94%), for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. • In 17 of 18 PNMPs reviewed (94%), instructions related to mealtime were included. • Eight of 18 individuals (33%) received enteral nutrition. This was clearly stated in their PNMPs. Five did not receive any oral intake. • In 4 of 18 PNMPs reviewed (22%), dining position for meals or enteral nutrition	

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		was provided. • In 14 of 14 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally. There were instructions for nothing by mouth for those with non-oral intake (100%). Only Individual #114 and Individual #54 were identified with oral intake g-tube feedings. • In 5 of 14 PNMPs for individuals who received liquids orally (36%), the liquid consistency was clearly identified. • In 11 of the 11 PNMPs for individuals who ate orally (100%), dining equipment was specified in the adaptive equipment section or there was a statement that adaptive eating equipment was not required for six of the seven others. No specification was noted for Individual #2. • In 0 of 18 PNMPs reviewed (0%), a heading for medication administration was included in the plan. Information for the other plans was included under other headings, though none were consistent. • In one of 18 PNMPs reviewed (5%), a heading for oral care was included. A primary intent of addressing oral care in the PNMP is to ensure appropriate position and, most importantly, proper alignment during oral hygiene/tooth brushing activities conducted by the direct support professionals several times daily. Another critical issue is related to whether the individual required thickened liquids or special techniques to assist with swallow/breathe synchrony. This is critical to ensure effective oral hygiene in a manner that is safe for those at risk for aspiration. There were no written instructions or pictorial support to direct staff in oral care strategies and techniques. • 18 of 18 PNMPs (100%) reviewed included a heading related to communication. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Eight of the 15 PSPs selected for review by the monitoring team were of the new format. Two were in the old format and completed on 11/10/10 and 10/6/10 for Individual #114 and Individual #93 respectively. Four PSPs submitted with not current within the last 12 months. PSP meeting attendance by PNM professionals was as follows: • Medical: 1 of 8 in attendance per the signature sheet. • Dental: 3 of 8 in attendance • Nursing: 7 of 8 in attendance • Physical Therapy: 2 of 8 in attendance • Nutrition: 0 of 8 in attendance (Diet Clerk or Tech 6 of 8) • Communication: 1 of 8 in attendance (Speech tech 4 of 8) • Dental: 3 of 8 dental hygienist in attendance	

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		It would not be possible to achieve adequate integration with the clear limitations in PNM-related professional participation in the PST meetings when these plans were developed. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. There was evidence of a discussion related to risk in the PSPs for Individual #54 (6/6/11) and Individual #72 (2/15/11) only, and did not reflect an interdisciplinary approach to discussion, risk identification, and intervention. There were discrepancies between the information reported in the PSP and the designated risk levels. For example, in the case of Individual #72, it was reported that he presented with reduced laryngeal elevation and epiglottic closure and, as such, was at risk for aspiration with all foods and fluids offered by mouth. He was designated only at MEDIUM risk for aspiration. It was also reported that he received gastrostomy tube feedings with NPO (nothing by mouth) status. He participated in the Frazier Water Protocol, but there was no discussion of his success with this program. His current PNMP indicated that he ate by mouth, though reference to tube feedings and the Frazier Water Protocol remained in place. There was no PSPA to address this significant change in his status and program. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** As stated, above poor attendance at PSP meetings and the lack of integration in the PSP negatively impacted the ability to develop the PNMPs in a comprehensive and collaborative manner. • There was no evidence of interdisciplinary PST discussion of the elements of the plan, its effectiveness, or need for modification. • There was no discussion of the frequency of PNMP monitoring indicated based on identified risks and needs. • In the case of Individual #66, the PST agreed that all supports should continue, however, there was no representation from therapies at the meeting so all discussion was based only on the written report submitted. **Standard: PNMPs are reviewed annually at the PSP meeting, and updated as needed.** There was evidence in each of the annual OT/PT assessments that the PNMPs were reviewed by therapy clinicians, however, there was no evidence of review by the PST in	

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		relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the PSP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full PST. The PNMPs were updated by the therapy clinicians based on change in status or need identification and indicated in the plan by the revised date, the PSP date (annual) and by symbols to highlight instructions that were added to the previous plan.	
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 with limited input by other PST members. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair, if he or she had one, or was to be readily available nearby, otherwise. In most cases, pictures were available with the PNMPs related to adaptive or assistive equipment as well as various positioning outlined in the plan. As reported during the last review these pictures were small, making it difficult to discern detail as to alignment and support. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright, described the angle of recline, seatbelt use and the type of transfer to be used. General practice guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation, but not always specified in the PNMPs. Dining Plans were noted to be available in the dining areas, though prompts were required in cottage 513 after 15 minutes without plans for nine individuals seated at the table and eating or drinking. Staff were observed to read the plan when asked a question, though reference to the plan before beginning the meal was inconsistent. In some cases, where an error was noted by the monitoring team, the staff was asked to read the plan. They were also not always able to recognize the error observed. Based on observations of individuals during meals across a variety of homes, a number of errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP. A number of examples are presented below in hopes that this detail will be useful to the facility: • Individual #52: A pitcher of thin liquids was within her reach on the table. During a previous review she poured liquids from the pitcher and drank thin	Noncompliance

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		liquids before staff were able to intervene. She was prescribed nectar thick liquids and was at risk for aspiration. • Individual #125: Observed to drink a full glass of liquids without stopping and no intervention from staff. He was identified at risk for aspiration. • Individual #40: She had a footrest attached to an adaptive chair which appeared appropriate for her, but she was too far from the table and it was too high for optimal alignment, support, and function. • Individual #105: His feet were not supported on the foot rests. There was no individual notebook readily available, though staff retrieved it upon request. • Individual #189: He was seated in his wheelchair with his pelvis not centered or well back in the seat. There was no individual notebook available, though staff retrieved it upon request. • No one was observed to be re-positioned prior to beginning their meal in any home. • The details of the dining positions were difficult to see from the pictures included in the Dining Plans. • Individual #70: His Dining Plan indicated that staff should support his jaw when offering fluids. Staff generally merely used cloth under his chin to capture fluid loss, but did not actually provide jaw support. The picture in his plan showed his head in hyperextension and this was noted when staff was presenting fluids. • Individual #128: She was observed sleeping in her walking device. When the monitoring team approached her, staff quickly attended to her and then transferred her to a mealtime chair at that time. The transfer was safe and appropriate, however. • Individual #70: The small picture of his wheelchair in his PNMP looked different than his current seating system, yet staff could not explain the rationale for the difference. • Individual #28: She was appropriately transferred to prone lying on a mat table, but staff did not attend to re-alignment and proper support once she was placed. • Individual #118: She was transferred from her wheelchair to an adaptive swing. There were no specific instructions related to this transfer in the PNMP dated 4/28/11. A PT tech was available to assist direct support staff. The DCS stated that she had been trained to complete a one-person lift to the swing while a second staff stabilized the swing so that is what was done. Both staff appeared to be confused as to the setup for this transfer. Both staff allowed her hips to extend before properly securing the seatbelt and, as such, she was not in proper alignment. She was not repositioned by staff. • Individual #127: She was observed being transferred to her wheelchair by a PT technician and DCS. While the mechanical lift transfer was properly done, they did not check and correct her alignment in the wheelchair before fastening her	

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		seat belt. They were prompted by the monitoring team to check for this and the PT tech did not recognize the problem. The staff were directed to reposition her and were able to move her back into the seat back and bottom more effectively. The only diet texture error noted was that which was reported during the previous review. Individual #90 was offered dry, un-moistened bread crumbs. The texture was correct per his Dining Plan, but the bread was too dry and created a risk for unsafe swallowing and aspiration of the bread crumbs. When staff were prompted, the SLP present brought gravy to the table for use with Individual #90. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Though improvements were certainly noted, particularly in the dining room for the Dorm area (Homes A, B and C), there were a number of errors in implementation, suggesting that staff did not fully understand the importance of these plans and the risks presented by the individuals they served. In addition, staff were not able to recognize when alignment was inappropriate in order to remedy or report it as a problem. See other examples in section P below.	
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.** • Staff training for New Employee Orientation related to PNM included the information about OT, Dining Plans, secrets to a successful mealtime, adaptive equipment, and sensory issues. • Additional NEO training pertaining to lifting and physical management as well as augmentative communication, dysphagia and eating behaviors and swallow safety and thickened liquid preparation. • Block refresher training was also scheduled for existing staff for lifting, dysphagia and eating behaviors and swallow safety with thickened liquid preparation. • Lifting was a designated one hour course and the other two were on half hour session each. Testing was via multiple choice tests in all areas except for lifting. Though practice checklists were available for participants these were not used in the training observed during the week of this review (mechanical lift transfer training) and there was no formal check off to establish competency. A tremendous amount of content was to be presented with the intent of establishing competency in a short time. Though by report, this training was competency-based, based on observation and review of instructional materials reviewed, this was limited primarily	Noncompliance

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		to written tests that in most cases did not even capture the important "take away" information important for staff application of classroom learning while on the job. While there were hands-on opportunities to perform transfers and thicken liquids, these practice sessions were considered the skills-based competency. The format for the class teaching staff to thicken liquids, did not allow them to pour and explore the various types of thickened liquids. They were taught verbally what color the boxes were for nectar and honey thick liquids but were not permitted to open them. One box of each was opened and the instructor poured the liquid out to compare them. As an aspect of their written test, one question directed them to prepare one type of thickened liquid. There had been no previous practice time beyond didactic instruction without demonstration of the task provided. This was not an acceptable training to establish staff competency in this area. It appeared that the individual-specific training that was provided related to mealtime was most often tested via a verbal response rather than by demonstration. The introduction of the annual refresher courses should begin to impact these concerns for existing staff as well as reinforce learning for new employees, but only if the curriculum is carefully reviewed and revised with the development of skill competencies that are taught via instruction, demonstration, and opportunities for practice with feedback. Testing should involve an outline of each of the steps necessary to complete the task and each would be checked off as it was correctly completed by the participant. Checklists must be sufficiently discrete so as to ensure proper evaluation of their abilities to demonstrate and apply specific skills necessary for knowledgeable and accurate implementation of PNMPs and Dining Plans. **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.** See above. **Standard: All foundational trainings are updated annually.** Refresher courses were currently being scheduled for existing direct support staff though each was based on the existing teaching content, format, and instructional materials. As described above these were inappropriate and inadequate in relation to dysphagia, swallowing and eating behavior, thickening liquids and augmentative communication. As such, these classes will also be ineffective and should be drastically modified. The monitoring team expects to see significant changes in this area in subsequent reviews. **Standard: Staff are provided person-specific training of the PNMP by the**	

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		appropriately trained personnel. Tools and checklists used to establish competency and documentation for staff trained to implement PNMPs and Dining Plans were submitted. This consisted of training rosters signed by participants. A description of the knowledge or skill trained was documented on the roster which appeared to imply competency, though this was not clearly stated and instead most likely only required a verbal response rather than a skills-based competency established via demonstration. **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.** Training was not consistently effective as evidenced by the implementation errors noted by the monitoring team and described above. The current system of monitoring had recently implemented a system of targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** There was no evidence that there was competency-based individual-specific training for staff before they worked with individuals who were at high risk or for pulled/float staff. Training for changes to plans was conducted by therapists, PNMPCs, and in some cases, by therapy technicians. Competency had not been clearly established via this system to date.	
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 formalized policy related to the process of PNM monitoring (lifting, transfers, positioning, mealtime, and communication). There was no formalized curriculum for training the PNMPCs. It was reported by the Habilitation Therapies Director that the clinicians trained the RTT IV staff and they in turn provided training to other techs and the PNMPCs. Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. A database developed to track PNM monitoring would also track the completion	Noncompliance

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		of validation checks with the PNMPCs. **Standard: Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).** Monitoring forms had been developed to address implementation of the PNMP, mealtime, lifting and transfers, and wheelchair and bed positioning. There was no mechanism to ensure that monitoring occurred during bathing, medication administration, or oral care. The mealtime monitoring had been scheduled in a manner to better capture all meals across the day as recommended by the monitoring team during the previous review. The monitoring schedules continued to be under development with the intent to base frequency on health risk indicators. Two meetings to initiate PNMP monitoring by the PST had been held on 6/17/11 and 6/21/11, though attendance was poor and no plan had been developed as of the time of this review, though monitors had been identified to include the five PNMPCs and therapy technicians, four psychology technicians, three assistive technology technicians, campus supervisors, and eight QMRPs. There was a database established to congregate data and to track compliance findings and analyze findings, issues, staff re-training, and problem resolution. Aspects of these elements were reviewed during monthly meetings by all clinicians, techs, and PNMPCs. 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. **Standard: All members of the PNM team conduct monitoring.** As described above this had only been initiated on 6/17/11 and 6/21/11, but no further action had been taken since that time. **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.** There was no system implemented to address monitoring by the PNMT at the time of this onsite review. The system used to track and trend findings should be available to the PNMT and used in their assessment and follow-up on action plan elements and person-specific outcomes that are measurable, meaningful and functional for the individual. **Standard: Immediate intervention is provided if the person is determined to be at**	

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		risk of harm. Immediate intervention was to occur if an individual was determined to be at risk of harm. The monitor was to notify the appropriate person, such as the charge, home manager, nurse, or therapist. The forms themselves did not provide a mechanism to document these actions or to document follow-up, but rather this was done in the computer database and could not be easily tracked.	
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 was introduced in January 2011 and the PSTs continued to face challenges in order to fully implement this process. Discussions with PST members were conducted with the monitoring team in an attempt to understand where the teams were with this and to hopefully move it along. **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 at least on an annual basis, or more frequently based on PST referrals, findings from scheduled monitoring, or other informal observations. In the case that an individual participated in direct therapy, progress notes were written, with monthly assessments intended to justify continuing or discontinuing the plan. More in depth discussion is addressed in provision P below. The system continued to need to be more fully developed and refined so as to ensure assessment of the effectiveness of the plans on a regular basis, in addition to the PNMP and dining plan monitoring conducted by the PNMPCs and soon-to-be others.	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	**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 11 to 14 individuals listed as receiving enteral nutrition (the number varied based on the information submitted by the facility). Eight of these individuals were included in the sample reviewed by the monitoring team. There was a new system for the annual review of those who received enteral nutrition by the PST using the Aspiration Pneumonia/Enteral Nutrition Evaluation. Evaluations completed for individuals in the sample were requested by the monitoring team. These assessments were noted for four individuals included in the selected sample (Individual #71, Individual #1, Individual #191 and Individual #178).	Noncompliance

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	individual to oral feeding.	• In the case of Individual #71 (assessment undated), he had resumed skilled trial oral feedings on 10/22/10, following an MBSS on 10/13/10. By report, he was tolerating nectar and honey (his preference) thick liquids and puree food items with no coughing or throat clearing, and no oral residue. Oxygen saturation levels remained in the mid to high 90s per progress notes provided. He was deemed to be ready for full meals orally per the SLP. SLP recommendations were outlined, but there were no team recommendations, measurable outcomes, or action plan steps outlined. Without these elements this assessment was not satisfactorily complete. • The document submitted for Individual #178 was merely an undated, blank assessment template and, as such, was also incomplete. • The document submitted for Individual #191 was dated 2/25/11, but included only a list of diagnoses and, as such, was not satisfactorily complete. • The undated assessment for Individual #1 included history and diagnostic findings. There had been no efforts to return to oral intake documented. The only current treatment listed was the identification of the need for a dental desensitization program and appropriate oral hygiene three times daily after meals and before bed. There was no discussion of her cooperation with daily brushing. Her oral hygiene was reported to be poor. She had a reported history of aspiration pneumonia, most recently in January 2011 and September 2010. There was no analysis of findings, recommendations, measurable outcomes or action plan and, as such, was not satisfactorily complete. The monitoring team expects significant and timely progress with these assessments prior to the next review. **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 in the selected sample had been provided a PNMP that included the same elements described above. **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 formal protocol outlined for this process. Transitions to oral intake had been initiated in the last six months for a number of individuals living at EPSSLC, four of whom were included in the selected sample (Individual #93, Individual #71, Individual #115 and Individual #2).	

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		• A meeting was observed related to this issue for Individual #2. Full access to critical information was not possible on this date due to the failure of the RN on this team to provide the appropriate vital sign documentation before and after each feeding. Though anecdotally, it was thought by the SLP that Individual #2 was tolerating oral intake well, there were no hard data available to guide the necessary clinical judgments. This group required prompting by the monitoring team to defer further action until this key information was made available. Unfortunately, this delayed her progress with oral intake. • As reported in the previous review, one SLP initiated oral intake with Individual #115 without an interdisciplinary assessment and development of a clear action plan. The PNMT was prompted to conduct this assessment with follow-up. It was of concern that there did not appear to be a clear understanding of how to approach this issue and it was very clear that a standard protocol was needed. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** As stated above, assessments for four individuals were reviewed and were found to be unsatisfactory. EPSSLC will require extensive modeling and coaching to ensure proper implementation of this process. **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 positioning and assistance techniques to ensure safe eating and drinking. Further focus on these areas should occur as the At Risk and PNMT systems are implemented.	

Recommendations:

1. Quickly identify the nursing PNMT member (O1).

2. Consider an increase in nutritional staff. Two part time dietitians for the facility and assignment to the PNMT was insufficient to adequately meet the needs of all individuals living at EPSSLC (131 individuals) (O1).

3. Revise documentation methods for PNMT meetings to better reflect data, problem-solving and analysis, actions, decisions, plans for interventions, monitoring findings, follow-up, and timelines for review (O1).

4. Conduct self-audits of Dining Plans and PNMPs to look at clarity, consistency of format, and content. Reviews should include a review of the flow of implementation throughout the day to ensure optimal compliance (O3).

5. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct chart review and history. Evaluations must be based on new data or information in order to yield a new perspective to address specific issues that drove the referral to the team (O2).

6. Abandon the current mealtime training and implement a well-designed curriculum with appropriate content, instructional methods, and materials. The focus should be on the development of staff knowledge and skills necessary for implementation of safe mealtimes (O5).

7. Ensure that competency-based training is skills-based whenever indicated. Staff generally learn better by learning and trainers get a better idea of the effectiveness of their training through return demonstration rather than mere verbal responses. Verbal responses do not suffice in the case that the staff need to perform a specific skill (O5).

8. Consider establishing a more interdepartmental implementation of the trend analysis of all monitoring data. Review findings and make system adjustments. 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 (O6).

9. Use a collaborative approach to assist the PSTs for improved activity analysis in the development of SPOs for teaching individuals to slow down or take smaller bites. Integrate strategies and prompts like taking a drink, using a napkin, or putting the utensil down for individuals who do not respond to verbal cues. Provide inservice training to staff regarding the appropriate use of physical prompts during meals to redirect (O5, O6).

10. All preparation for the subsequent onsite review should be directed by the Department Director with key professional staff to address content areas. The strategic action plan should drive the activities of all staff and routine review of the status on all action steps should be conducted frequently. The development of the POI should be clearly related to activities conducted to assess status based on chart review observations, training drills, and so forth, and the actual implementation of actions in the strategic plan with documentary evidence. These should be reported in the POI and serve as the foundation for the assignment of compliance or noncompliance status by the facility. The document request should be put together in a thoughtful, organized manner and if there are questions as to what is being requested, the Director should seek clarification (O1-O8).

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 OT/PT Staff list o OT/PT Continuing Education documentation o EPSSLC Organizational Charts o Staffing data (5/31/11) o Section P Presentation Book and POI o EPSSLC Organizational Chart o Current Census By Home o Admissions Activity 1/1/11 – 6/16/11 o Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Physical and Occupational Therapy o PNM Needs list o Individuals receiving direct OT/PT o List of hospitalizations/ER visits o PNM Monitoring form template o Requested of Observed Monitoring Form template o Completed PNMP Monitoring Forms submitted o PNMP monitoring spreadsheets o Documentation from monthly PNMP monitoring meetings (November 2010 to April 2011) o NEO training curriculum for PNM o PNMPs submitted o PNM Maintenance Log o Work Order Spreadsheet o PNM spreadsheets o OT Assistive Equipment List o PNMP Assistive Equipment List o OT/PT Referral Source and Follow-up Database o Mat Assessments and Assistive Technology Evaluations for Individual #30, Individual #82, Individual #69, Individual #66, Individual #195, Individual #2, Individual #54, Individual #189, Individual #127, and Individual #16. o Risk Level Rating of High o Risk Level Rating of Medium o High Risk POI Information as of 6/15/11 o List of individuals with enteral nutrition o Decubitus Ulcer Record 2011 o Injuries Fracture- Suture-Dermabond (12/1/10 – 5/30/11)

	o Falls Incidents 12/1/10 – 5/30/11 o Total Pneumonias (9/1/10 0 6/17/11) o Individuals who were non-ambulatory or assisted ambulation o Individuals with Primary Mobility Wheelchair o Individuals who Use Transport Chairs o Individuals with Orthopedic Devices and Braces o Ambulation Assistive Devices – Gait Belts o Individuals who require assisted ambulation o Individuals who were non-ambulatory o SPOs and related documentation for OT/PT interventions for Individual #191, Individual #178, Individual #2, Individual #84, Individual #66, Individual #82, and Individual #152 o OT/PT evaluations and PSPs for Individual #144, Individual #162, Individual #12, Individual #113, Individual #116, Individual #123, Individual #128, Individual #37, Individual #24, Individual #66, Individual #164, Individual #28, Individual #67, and Individual #61. o Information from the Active Record including: Personal focus Assessments, PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, Annual Medical Summary and Physical, Active Problem List, Hospital Summaries, GI Consults, Orthopedic consults, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab I included Communication assessments and updates), Nutrition tab and PNMP tab for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o PNMP section in Individual Notebooks (included communication books and dictionaries) for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o Mealtime Observation/PNMP monitoring sheets for last six months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o Assessments, SPOs, and other documentation related to speech treatment for Individual #56, Individual #63, Individual #50, Individual #39 and Individual #172. <u>Interviews and Meetings Held</u>: o Anderson Hicks, OTR Habilitation Therapies Director o OTs and PTs o Therapy Technicians

	o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o NEO training o PSP meeting for Individual #2
	Facility Self-Assessment: EPSSLC submitted its self-assessment for this provision (POI), updated on 7/1/11. In addition, the monitoring team requested that the director review the Presentation Book onsite. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements, or the status of a variety of tasks, since the previous review in January 2011. The correlation of these tasks to each provision was not always clear. Also, there was no mechanism to determine how the facility had determined noncompliance with each item in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Physical and Occupational Therapy Guidelines self-audit tool was included in the Presentation Book, but no completed audits or analyses of audits completed in the last six months were included. It was reported that therapy assistants were completing these and that techs had prepared the Presentation Book. A list of Action Steps were included in the POI, but were not related to a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. None of the action steps listed were completed, though three of these had projected completion dates of 6/15/11. Two of the 14 had not been initiated to date. This approach appeared to merely document completion of tasks rather than to serve as clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be shorter-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Example action steps stated: • Include PSP members in the development of the individual's PNMP (10/31/11 completion date) • Provide competency-based NEO and Block Refresher PNMP training for designated staff (12/31/11 completion date) These were essentially redundant statements from the Settlement Agreement provision and did not offer any specific steps or actions to make that happen.

	The monitoring team concurs with EPSSLC self-assessment of noncompliance for each of the elements in section P.
	Summary of Monitor's Assessment: The OT and PT staff were strong clinicians who worked well together and strived to improve the delivery of supports and services at EPSSLC. Staffing for OT had increased significantly. Assessments were improving with efforts to begin to link the health risk assessment process to the OT/PT assessment process and in the development of the PNMP. The focus continued to be primarily on health risk, though there were notable efforts to address functional skill acquisition. Most of the goals established were measureable, but the performance criteria were lacking in that it was not clearly stated how it would be known that learning had occurred. Meaningful and functional learning opportunities must be recognized as equally important as physical health concerns and that independence, engagement and participation are also critical to positive health outcomes for individuals. The assessments were generally improved since the previous review. There were sections that addressed health risks with analysis and rationale for the associated interventions with a separate report of the risk issues identified by the PST. While this was a positive step, this should be linked to the PST designations for risk to ensure full integration. The sequence of this discussion in the OT/PT assessment report was awkward in relation to the PNMP review and the integrated summary. There was analysis of information scattered throughout the report rather than at the end after a thorough presentation of the data. Another positive was addressing the potential for skill acquisition sections, however, greater consideration for actual potentials for participation was indicated. In some cases it was determined that individuals did not have potential for skill acquisition due to the fact that they were functioning at baseline, suggesting that the only rationale for intervention was regression. Efforts to identify the rationale for some supports were noted in the comprehensive assessments. There was no comprehensive analysis of findings that included both health and medical concerns with a description of functional skill abilities and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs. Though equipment generally was available, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standard of care. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. The NEO session related to transfer instruction was observed during the week of this review and was very well organized with excellent instructional methods used by the PTA and COTA trainers. It was noted and brought to the attention of the instructors that it was critical that staff be required to follow through with each transfer to finish with properly aligning the individual. In most of the practices, staff were released as soon as the model was placed in the chair. There appeared to be a clear link to this gap in instruction and hands on practice/return demonstration with the observations by the monitoring team.

	Monthly reviews of monitoring results continued to be conducted. This process should become more formalized and perhaps evolve into a facility-wide group to examine trends and specific implementation issues that require collaboration across disciplines. It was of concern to the monitoring team that in some cases PNM supports and services identified as necessary for an individual were not provided due to the lack of sufficient staffing. The response to the document request for this provision was not well organized and, in many cases, the information requested was not provided and/or a tremendous amount of unrelated documents were submitted. It did not reflect well on the department.

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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.** Current staffing was increased since the previous onsite review and included two full time PTs, one part time PT, one PTA, three full time OTRs, and one COTA. Verification of a current license was submitted for each of these clinicians. The PTs were under contract and there was one unfilled position. There were four therapy technicians, with one in NEO. There were five Physical Nutritional Management Coordinators (PNMPCs). The only continuing education documented for these clinicians was listed as participation in two state-sponsored webinars on 1/18/11 and 1/20/11. Fabrication and maintenance of seating systems and other assistive technology continued to be conducted onsite with one fabricator and two technicians. The head fabricator, Roberto Osuna, had previous experience in the furniture industry and in industrial design. This was his first job as a fabricator of wheelchairs and he would benefit from continuing education to provide the knowledge and skills needed to appropriately provide this service. Opportunities to visit other SSLCs would also be beneficial to him. All of the 131 individuals, that is, 100% of the current census were identified as requiring PNM supports and were provided a PNMP. Based on the reported census and identified PNM needs, as currently staffed, the caseloads were 65.5 each for PT and 43.7 for OT. The staff to individual ratio was listed by the facility as 1:66 as of 5/31/11 for PT and 1:22 for OT. These figures appeared to be consistent relative to PT, but it was not clear as to how the ratio was calculated for OT. Functionally, the clinicians divided responsibilities between the Dorms and the other homes. OT and PT Assistants served as adjunctive staff because they were not licensed to conduct assessments or develop intervention plans,	Noncompliance

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		requiring supervision by OTs and PTs, respectively. They were able to provide interventions, staff training, monitoring and other responsibilities. The existing PTs, PTA, and COTA appeared to be strong competent clinicians and had worked at EPSSLC since the baseline review. The OTs were new to the facility since the previous review and one was a new graduate (license issued in May 2011). Each was a much needed addition to the department. The monitoring team looks forward to working with them in subsequent onsite reviews. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the therapy assistants or aides. Annual assessments/updates were completed by OT and PT, collaboratively. Some of those who did not have established PNM needs required occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. OT/PT assessments were reviewed for 15 individuals. Of these, 14 were identified as an OT/PT Comprehensive Assessment and one was identified as an Initial OT/PT Assessment (Individual #191). Each was current in the last 12 months. Additionally, most current assessment samples from each therapist (five each) were also requested, but a number of these were duplicated. The total number of assessments included for review was 19. Based on these assessments, at least 17 of the 19 (89%) individuals were identified concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Most of the recommendations were for a variety of indirect services via the PNMP, the provision of assistive equipment, and/or orthotics, and dining supports. Six individuals were recommended for OT or PT services beyond the PNMP (Individual #21, Individual #1, Individual #178, Individual #191, Individual #123 and Individual #116). Overall, however, at the facility, a total of six individuals received direct OT services (Individual #191, Individual #178, Individual #6, Individual #13, Individual #2 and Individual #78) and seven individuals received direct PT (Individual #84, Individual #191, Individual #66, Individual #152, Individual #9, Individual #82 and Individual #2). **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Assessments were completed rather than screenings. The assessments submitted were completed by both OT and PT. As stated above, there were 19 assessments included for	

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		review. One individual was recently admitted, but had not been available for services because he was transferred to Triumph Medical Center following his transfer from Denton State Supported Living Center to EPSSLC. This assessment was initiated within 24 hours. The previous new admission to the facility was Individual #144 and the OT/PT assessment was completed within 24 hours, well within the 30 day minimum. An assessment tracking log was requested. The OT/PT Referral Source and Follow-up database was submitted, though annual assessments were not included in it. The existing schedule was to complete annual assessments/updates for each individual with PNM needs (131 per the current documentation). Interim issue-specific assessments were completed as needs were identified and tracked in this database. It was not possible to determine if all individuals had received an OT/PT assessment in the last year, though 8 of 15 individuals (53%) had an update present in the record from the previous year. Most of the others had received some type of interim issue-specific assessment by OT and/or PT. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** While the Settlement Agreement indicated that assessment should occur within 30 days of the identified need, this standard is not acceptable when there are urgent issues with potential for further injury or health and safety risks. The OT/PT Referral Source and Follow-up Database was submitted for 1/4/11 to 5/23/11. There were approximately 295 entries for referrals and subsequent assessments. While most were responded to well within the 30 day range, there were 26 entries in which the assessment was completed well outside of the 30 day window (89% compliance), yet the database documented 100% compliance. An example submitted in the Presentation Book included a PT Assessment for Individual #82 on 5/24/11 in response to a referral on the same date due to unsteadiness reported by direct support staff. This was also present in the database submitted. **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.** Per this standard, each individual at EPSSLC should receive a minimum of a comprehensive assessment every three years with interim updates because all had been identified with PNM needs. Each of the individuals included in the sample had received a comprehensive assessment within the last 12 months, though only 8 of 15 individuals had	

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		received an update the previous year (Individual #71, Individual #154, Individual #21, Individual #178, Individual #16, Individual #72, Individual #39 and Individual #115). It would not be unexpected, however, that upon entry of a new comprehensive assessment, any previous comprehensives and updates would be purged from the individual record. The assessments were each generally consistent with regard to format with no differences between the updates and the comprehensive reports. The assessments did not, however, make reference to a previous assessment in any way. EPSSLC presented the case of Individual #66 as an example to the monitoring team. An issue-specific assessment was dated 2/17/11, following a referral on 2/15/11, regarding pressure mapping for a new wheelchair and, as such, was not comprehensive in nature. There was no statement in the assessment to indicate that this was related to a change in status and it was unclear why this had been submitted as an example. The monitoring team requested additional information and found that Individual #66 received a Comprehensive Assessment on 4/4/11 and updates each previous year on 4/15/10, 4/7/09, 4/2/08, 4/10/07, 4/11/06, 5/9/05, and 5/21/04. The assessments were generally improved since the previous review. There were sections that addressed health risks with analysis and rationale for the associated interventions with a separate report of the risk issues identified by the PST. While this was a positive step this should be linked to the PST designations for risk to ensure full integration. Further, information contained within this report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. The sequence of this discussion in the OT/PT assessment report was awkward in relation to the PNMP review and the integrated summary. There was analysis of information scattered throughout the report rather than at the end after a thorough presentation of the data. Another positive was the potential for skill acquisition sections, however, even greater consideration for actual potentials for participation is needed. For example, in the case of Individual #71, it was stated that he had limited potential for skill acquisition in ADLs due to his lack of active range of motion. It was described, however, that he enjoyed holding objects in his hands and that he had good head and neck control in sitting. There was no evidence that he had been considered for holding a self-care object during the activity (i.e., holding a toothbrush, a brush or wash cloth). These types of activities may be integrated into existing SPOs and/or may be coordinated with communication goals. He was provided a padded rocking chair, but there was no evidence that there had been consideration for a means to ask for it. In addition, it was not clear whether he had the potential to use his head or cheek to learn to activate a switch for communication purposes or environmental control.	

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		Other issues noted in the assessments reviewed included: • The clinical reasoning used by the clinician to guide the development of an intervention plan was not clearly stated in the reports. Even though the assessments provided functional examples of systems level findings, such as range of motion, strength, and muscle tone, this information was not consistently utilized to guide decisions regarding intervention. • There was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. The following information was also noted; these individuals would likely require supports and interventions by OT and/or PT beyond only a PNMP. There were: • 131 (100% of the current census) individuals identified with PNM needs per the list submitted. • 24 (18 %) individuals identified as non-ambulatory and 27 (21%) as requiring assistance for ambulation. • 56 (43%) individuals required a gait belt for assisted mobility and/or transfers. • 39 (30%) individuals who used a wheelchair as a primary means of mobility. • 24 (18%) individuals who used transport wheelchairs as needed. • 37 (28%) individuals with upper or lower extremity orthotics and/or braces • 5 (4%) individuals sustained an injury resulting in a fracture. Three others required sutures or staple due to a slip, trip or fall. • 10 (8%) individuals had experienced one or more falls in the last six months. Two of these incidents occurred in the bathing area. One individual experienced a slip, trip or fall resulting in a serious injury. Individual #115 was identified at high risk for falls, 13 others were considered to be at medium risk. • 10 (8%) individuals had one or more incidences of pressure ulcer in the last year. • 3 (2%) individuals were diagnosed with aspiration pneumonia. Three others were listed with bacterial pneumonia though received enteral nutrition. • 8 (6%) individuals were listed at high risk for osteoporosis. Eight others were considered to be at medium risk. As the PSP and Health Risk Assessment processes are refined over the next year, they will likely further impact the content, analysis and recommendations in the OT/PT assessments over the next year.	

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		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)** As stated above, the assessments generally addressed range of motion and movement skills, such as transfers and ambulation. Other functional skills were more consistently addressed, particularly in the area of fine motor skills and activities of daily living. Clinicians were more routinely providing a description of the level of participation, such as raising their arm during dressing. In a number of cases, it was reported that these activities had been observed by the clinicians. There was, however, a consistent statement across assessments that the individual functioned at baseline and had not regressed since the previous assessment. There was, unfortunately, little consideration for the potential for learning new skills via training objectives. **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.** Also submitted in the Presentation Book were assessments for Individual #70. He received a variety of indirect supports via custom shoe inserts and a PNMP. There were two PT Assessments post hospitalizations on 4/21/11 and 5/28/11. There was no such assessment conducted by OT, however. Ideally this review would have been conducted in an interdisciplinary manner. An additional assessment for Individual #70 was dated 1/18/11 following a PST recommendation that he learn to self-propel his wheelchair outside on the sidewalk for active participation in the community re-entry program. An informal training program was developed rather than a SPO. His annual OT/PT assessment had been completed on 12/20/10, just one month earlier, yet the clinicians had not identified this as a need. Further, the OT stated that he was stable and that OT services were not needed. It was of concern that the clinicians did not recognize a need for increasing or enhancing existing skills. This was a consistent finding by the monitoring team based on reviews of the assessments submitted. **Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment.** The assessments did not typically recommend further specialized evaluations for wheelchair seating or for other issues because these were typically assessed at the time of the comprehensive evaluation. Related to this indicator, an assessment and letter of medical necessity were submitted for	

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		Individual #116 in the Presentation Book. The assessment dated 3/4/11 indicated that due to a steady increase in the need to use a wheelchair over the previous year, it was recommended that one be purchased for her. There was no recommendation for an actual seating assessment. A letter was dated 4/21/11 over six weeks later requesting a personal wheelchair with justification of medical necessity. It was not determined from the documentation if this equipment had been provided to Individual #116. Further she was not listed with a PT SPO on the list of direct services. The annual assessments typically provided a thorough description of the seating system components for individuals with a rationale for their selection, and consistently addressed whether the system was appropriate as to fit, function, and condition. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** As reported above, a section that addressed health risks with analysis and rationale for the associated interventions had been included in the assessment template. Though content and detail varied, this was present in 19 of the 19 assessments. However, only four addressed the risk levels established by the PST. Two of these also referenced the Aspiration Pneumonia and Enteral Nutrition Assessment findings. Despite these links, the risk indicators identified by the clinicians did not correlate with those established by the PST. For example, the assessment for Individual #54, dated 5/12/11, identified fracture risk due to osteoporosis and a previous history of a clavicular fracture. However, the PST had identified him at low risk for fractures. This inconsistency was not identified by the clinicians and there was no recommendation offered for reconsideration of this issue by the PST. The risks addressed in the OT/PT assessment should be consistent with those established by the PST. At any time that there was evidence that the risk rating should be modified due to a change in status, the PST should meet to review this. The PNMP should be modified as needed to reflect these changes. This should also be reflected in the OT/PT assessments. Information contained within the OT/PT report should contribute to the team discussion to determine risk levels. If there was a rationale for a difference in these ratings identified in the annual assessment this should be stated in the report for PST consideration. Risk levels identified by the collective PST should then in turn drive the supports and interventions via the PNMP and other more direct services provided by the therapists to assist in addressing those concerns. The sequence of this discussion was awkward in relation to the PNMP review and the integrated summary. There is analysis of information scattered throughout the report rather than at the end after a thorough presentation of the data prior. Efforts to identify the rationale for some supports were noted in the comprehensive	

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		assessments. There was no comprehensive analysis of findings that included both health and medical concerns with a description of functional skill abilities and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs. The documentation submitted in the Presentation Book related to this indicator included two PT Assessments (Individual #5 and Individual #15). Each of these merely listed PNMP health risk indicators. There were no references to the risk levels established by the PST and there was no evidence that the risks were addressed through the assessment process. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated.	
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	**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.** Each individual at EPSSLC had been identified with PNM needs and, as such, was provided a PNMP. These plans were reviewed by the therapy clinicians as an aspect of the annual assessment and there was no more frequent routine review. Implementation of the plans was monitored by the PNMPCs and the plans were revised as needed. Changes were identified by a symbol to alert staff to a change from the previous version. SPOs were developed to outline direct therapy and interventions for OT (6) and PT (7) though these were not consistently integrated into the PSP. Each of the plans was written clearly, though inconsistently contained functional measurable goals, objectives, and performance criteria. Documentation was consistent via daily progress notes, though these were filed in the Habilitation Therapies tab rather than included as an aspect of the integrated progress notes. Some examples that demonstrated the disorganization and inconsistency of SPO usage / skill acquisition are below (also see comments in section S): • Individual #84: The PNMT (11/10/10) recommended a SPO to improve his mobility with a gait trainer to reduce his fall risk. This was discontinued on 12/23/10 due to lack of progress related to refusals and SIB, lack of attention, absent safety awareness, and uncontrolled ataxia. His OT/PT evaluation, dated 12/29/10, stated that PT services were not indicated because he functioned at baseline in the areas of transfers and ambulation. After numerous falls, an SPO was written to begin 4/12/11 with the objective: "Ambulate on level surfaces	Noncompliance

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	minimize further regression.	using modified gait pacer with staff providing supervision to CGA for steadying/intervene for safety as needed." There was no measurable performance criteria established. Intervention was provided 18 times. It was reported that he had improved ambulation, but it was determined that the gait pacer was not an appropriate device for him. He was discharged from PT due to a plateau in progress and failure to achieve the goals due to poor compliance and unsafe behaviors even though he was reported to be compliant with treatment in 12 of 18 sessions. As there was no specific measurable goal there was insufficient rationale to discontinue PT. Further, there was no evidence that this had been integrated into the PSP or via a PSPA. • Individual #152: The OT/PT Comprehensive Assessment (1/7/11), identified a recommendation for weight bearing in a standing frame in combination with a leisure basketball activity for osteo-fitness. The SPO was dated 5/11/11 and identified objectives of standing in the standing frame for 20 to 30 minutes while engaged in an activity of his choice. In addition, staff were to demonstrate independence with sit to stand transfer into the standing frame box. This appeared to be a tolerance program to increase his time in the standing frame and would be considered a service plan rather than a skills-based plan. It was not appropriate to include the objective for staff performance in the individual program plan because this was a methodology for transition to direct support staff and not an objective for Individual #152. On 6/10/11, it was documented that he had met his goal. He was discharged from direct therapy by PT with the establishment of a Health and Wellness Program, two to three times weekly. • Individual #178: There was an activity plan dated 6/3/10 with a purpose to improve strength, endurance, and weight bearing as well as to reduce the risk of contractures. An SPO stated that he would independently propel his wheelchair from his home to building 515 (500 feet) though there was no additional documentation reflecting implementation until 8/2/10. A different SPO with a start date of 8/2/10 stated that he would increase his strength to self-propel his wheelchair from his home to building 515 on a daily basis. Progress Notes documented sessions through 10/2/10 when the reassessment reported that he continued to make progress and was able to propel outdoors for 400 feet. On 10/8/10 the SPO was put on hold secondary to a superficial skin abrasion to the left scrotum. There was no further documentation until 12/2/10 when it appeared that intervention had resumed, but there was no rationale for the extended hold or for the resumption of services at that time. A reassessment dated 12/27/10 indicated that he continued to make progress, but did not specifically report his status with the stated goal. The data reported varied with statements regarding distance covered or time propelling. The target distance was not stated in the new goal. On 2/11/11 it was reported that intervention was	

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		on hold due to torn sutures. There was no additional information related to his condition, though on 2/16/11, there was reference to a surgery site. No other information was provided. On 3/22/11, it was reported that he propelled himself from cottage 507 to building 515 and on 5/2/11 it was reported that he had met his goal and would be discharged from PT. The program was to continue as an aspect of his PNMP and through participation in the Health and Wellness program, two to three times a week for six months. There was no evidence of this active SPO in his PSP dated 3/7/11. In addition, on 5/27/11 he returned from a hospitalization where he was issued a BIPAP machine with oxygen tank and mask. He had a new diagnosis of congestive heart failure. There was a PT reassessment post-hospitalization on 6/20/11. The assessment was incomplete per copy submitted, but it appeared that it was recommended that he continue to self-propel his wheelchair per his PNMP though he required increased time. A number of Program Change forms were submitted in the records related to a variety of issues. Most of these were located in the Habilitation Therapies tab, but in some cases these were noticed with the more recent integrated progress notes. Clarification of these forms was obtained from the facility: these were used to originate a change in an individual's current program (PNMP or SPO, for example). This form was to be taken to the team for signatures, though only the QMRP signature was required. This served to inform the PST of the change. All of the changes made during a quarter were to be included in the Quarterly report by the QMRP for review by the PST and to integrate those changes into the PSP at that time. Though requested, quarterly QMRP reviews were generally not submitted for review and this practice was not validated by the monitoring team. Also, it was reported that OT and PT, and in the future, SLPs, were using the program change form to communicate all interactions regarding individuals. A copy of this form was to be placed in the integrated progress notes section. All documentation by the clinicians was also sent to the PST via email. It was confusing as to why this form was used rather than just a progress note. Further clarification of this system would be helpful for future reviews. One example of the use of this form was noted for Individual #154 who had been evaluated by PT secondary to a spiral fracture of her left lower extremity. The assessment was dated 5/7/11 and 5/8/11 with recommendations updated in the report following a PST meeting on 5/9/11. Those recommendations were documented in the Program Change report dated 5/9/11 and placed in the Integrated Progress Notes. The assessment was filed in the Habilitation Therapies tab. **Standard: Within 30 days of development of the plan, it was implemented.** As the limited interventions provided beyond the PNMPs were not consistently integrated	

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		into the PSP, 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, per the progress notes reviewed. Interventions initiated were generally consistently implemented, though the rationale for gaps in service was not well documented. Despite an order for therapy, the clinician had a responsibility to establish a clear justification for therapy and a specific plan of treatment with measurable and functional goals and outcomes. Likewise, continuing or discontinuing an intervention required an adequate and appropriate rationale and justification. All therapy-related SPOs should be an action step in the PSP. They should also be subject to routine PST review with reported data related to progress. **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.** There was inconsistent analysis of findings in the assessment reports to provide a rationale for the PNMPs developed for individuals or for other interventions, as described above. There was a general rationale identified on the plan itself rather than the specific supports in the statements of focus, however, these statements were not always consistent with the risks identified by the PST. Rationale was also offered in the recommendations rather than a section that outlined the clinician's clinical reasoning as a foundation for the recommendations. The Integrated OT/PT Collaborative Summary typically provided a rationale that services were not indicated for skill acquisition because the individual was performing at baseline. The whole idea for skill acquisition is for the individual to move beyond baseline performance so this rationale was not acceptable. PSP Addendums were not developed to address modifications to PNMPs and other therapy interventions for individuals as described above. Program change requests were consistently completed by the clinicians, but it was not clear that those served as addendums to the PSP. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** The primary support provided was via the PNMPs. PNMPs provided staff instructions or precautions related to assistance and supports for positioning, transfers, handling, and mobility. Additional areas addressed included communication, food texture, allergies, dining equipment, and mealtime instructions. Assistive equipment was included, as well. The focus statements were intended to identify the justification for the supports outlined in the plan. Bathing instructions were provided in the PNMP for 13 of 15 of the plans for individuals included in the sample. Oral care instructions were provided in the PNMP for	

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		1 of 15 of the plans for individuals included in the sample. Instructions for medication administration were noted for 0 of 15 individuals included in the sample. The Presentation Book provided assessments of individuals who had received therapy supports to address a need related to mobility, range of motion, independence, etc. For example, a number of individuals participated in ambulation programs with gait trainers and other assistive devices with PT, FEET, and the Health and Wellness program. The adjunct programs were excellent methods to address these issues, but as previously stated, it was important that these be evaluated for potential to be actual skill acquisition programs, rather than for maintenance only. Most of the SPOs currently designed and implemented by the therapists were short-term programs that were then integrated into the PNMP, turned over to direct support staff. Many of these perhaps could continue as skill acquisition plans with new or revised goals and data collection by support staff with oversight and review by OT or PT. **Standard: The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The assessments inconsistently provided a rationale for the specific equipment recommended for use, though the rationale for the wheelchair seating was more consistently noted. Positioning instructions with pictures were provided for staff reference as an adjunct to the PNMP, though these were small and difficult to see specific detail. **Standard: Therapists provide verbal justification and functional rationale for recommended interventions.** There were few intervention plans, and measurable goals were not consistently established with performance criteria clearly outlined. Documentation was consistent and, in some cases, described progress, but without a clear baseline and/or a specific measurable goal, continued intervention was not well justified. As a result, the decision to continue therapy or discharge was not sufficiently supported. It was likely that there was an adequate justification for many of the supports and services provided, but they were not always well documented. In addition, much of the documentation lacked sufficient detail to provide a thorough picture of the reason an individual was being assessed, or to track issues through to closure. A PT assessment as per referral, for example, should be able to stand alone in that it provides background information, presents the current problem, objective findings	

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		from the assessment, the clinical analysis by the therapist and a plan of action with recommendations. Subsequent notes or follow-up should refer back to this plan and relate clearly to the stated problem. Notes should continue until there is problem resolution. When there is a gap in service, the rationale should be explained fully. **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, documentation was noted daily or per session with monthly reassessments in most cases. These did not provide a comparative analysis of progress from month to month, however. Documentation for direct services was not included in the integrated progress note section, but rather separate from the rest of the program documentation and the integrated progress notes. Reviews of the PNMP were conducted annually, upon referral, or based on the findings of monitoring. There was evidence of the therapists addressing some issues identified through monitoring or referral, yet documentation of follow-up through to resolution was inconsistent. The monitoring team noted consistent follow-up for individuals post hospitalization, problem-oriented referrals, changes in setting or transition and based on findings from monitoring conducted by the PNMPCs. As stated above, however, the documentation needed improvement with regard to completeness of information to allow other team members to follow the issues through to resolution without researching other documentation to fill in the blanks (Individual #178).	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standard of care. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair. No one was observed being repositioned prior to their meal, and a number of individuals were not appropriately aligned or supported. Most of the transfers completed by staff were properly done, though attention to personal body mechanics needed improvement. Most staff (including therapy techs) stopped short of completing the transfer by re-aligning the individual once they were placed in their wheelchair or other device. In most cases, the individual was left in a posterior pelvic tilt, not positioned well back in the seat, or well aligned with appropriate support to the extremities. The NEO session related to transfer instruction	Noncompliance

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		was observed during the week of this review. It was noted and brought to the attention of the instructors that it was critical that staff be required to follow through with each transfer to finish with properly aligning the individual. In most of the practices, staff were released as soon as the model was placed in the chair. There appeared to be a clear link to this gap in instruction and hands on practice and demonstration. It is critical that the PNMPCs confidently and consistently apply their knowledge and skills in their interactions with direct support staff to ensure appropriate implementation of all aspects of the PNMP and other supports. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** The transfer training aspect of NEO training for direct support staff was observed during this onsite review. The trainers were the COTA and PTA. The instructional design was excellent and the therapists were very competent as teachers of the material. They were interesting speakers, they used humor appropriately to make the subject matter interesting, and they provided a good balance of didactic instruction, demonstration, practice, and return demonstration. Though the training was described as being competency-based, however, based on the fact that all participants required coaching throughout each step, none of the six participants would be considered competent to perform a mechanical lift transfer. Each would require additional practice and a competency check off with established passing criteria (i.e., performance standards met without coaching or further instruction). Individual-specific training was also reported to be competency-based. Licensed therapy staff provided inservice training to direct support staff, therapy techs, and to PNMPCs. PNMPCs also provided inservice training to direct support professionals. There was no established curriculum for training of the PNMPCs developed or implemented. **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 with staff names listed on the monitoring forms. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. When an issue was identified by the monitor, retraining occurred though in many cases it was documented as a "reminder" to staff. There was no evidence that a competency-based training occurred in conjunction with the findings of the PNMPCs.	

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		Standard: Staff verbalizes rationale for interventions. The staff were not confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing in relationship to the PNMP and other responsibilities. For example, in the case of Individual #52, staff were to provide one to one supervision for her when she removed or refused to use her oxygen via nasal cannula. When the staff assigned to her was asked why she was one to one, she stated the purpose was merely to encourage her to use the oxygen/insert the nasal cannula. The staff continued to stand over her, repeatedly offering her the oxygen, but being refused by Individual #52. This was reported to a nurse who readily cajoled her into compliance in a very short time. Upon interview with the nurse regarding the role of staff, he stated that staff were to monitor her for signs and symptoms, such as difficulty breathing, blueness in the lips, etc. He stated that he recognized that this staff required additional training with regard to this. The rationale for interventions and supports was stated in the focus statements of the PNMP, but in many cases these were general in nature rather than specific to strategies outlined in the plan. The clinicians appeared to be strategically addressing this issue as the PNMPs came up for review. 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 consistently indicated on the PNMP. Ongoing coaching and drills with staff related to risks and the rationale for interventions and supports was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues. There was increasing evidence of this noted on the PNMP monitoring sheets with the "rapid fire" questions. This practice should be continued and expanded.	
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	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** As stated above, adaptive equipment was reviewed on at least an annual basis at the time of the PSP assessments, in addition to review per referral by the PST to address fit and function. This was conducted by the licensed therapy clinicians. There was no system established for the clinicians to proactively review equipment for fit and function on a quarterly schedule. Monitoring by the PNMPCs was routinely conducted to review the availability of equipment, the condition, and to document any associated problems with the equipment	Noncompliance

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	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.	or its use. Most individuals were monitored on a monthly basis, while others were monitored more frequently. Individuals were scheduled for monitoring based on risk (though not necessarily based on the current risk assessment process) or other factors identified by the therapy clinicians. By report, this schedule was dynamic to reflect the change in risk levels and health status. The PNMP Monitoring form included indicators to address availability, cleanliness, condition, and fit. It was of concern that this aspect of monitoring by the PNMPCs was intended to address fit because this would be beyond the scope of the PNMPCs as paraprofessionals or non-licensed staff. The form asked the monitor to answer yes or no that there was "good fit." A judgment as to the proper fit requires assessment to determine not only if it fits as to size, but whether the components are adjusted properly to fit the individual and provides the desired support and alignment. It would be more appropriate for the monitor to document in the summary of findings when they questioned the fit of a device or that there were problems with alignment and support and then report those concerns to a licensed clinician for a follow-up assessment. As there was no system established for the clinicians to review equipment for fit and function on a more frequent basis, such as quarterly or other individualized schedule the clinicians were dependent on others to accurately report concerns in a timely manner rather than approaching this more proactively. A system existed for clinicians to request additional monitoring to be conducted by the PNMPCs or therapy technicians to follow up on an identified problem, or after inservice training to ensure continued compliance with implementation. For example, documentation related to this indicator was submitted in the Presentation Book for Individual #5. Per a PT SPO, he was to wear an AFO on his left lower extremity with orthopedic shoes for ambulation activities. The shoe insert was to be removed at that time. Requested monitoring of compliance with this was to occur twice daily, in the AM and PM. This was an excellent concept, however, the spreadsheet submitted documented that monitoring occurred only on 5 of 14 possible occasions from 2/1/11 to 2/9/11. It was reported on those five occasions that compliance with those instructions was 100% (2/1, 2/4, 2/7 and 2/9/11). While this system was in place, the implementation needed improvement for consistency in implementation. Additionally, observed monitoring was conducted to document issues noted informally. The current database included all types of monitoring and as such would likely bias the overall findings if analyzed for compliance. For example, if a PNMPC noticed a problem as he or she passed through a home, the system would permit the issue to be documented, but would lend a bias to noncompliance because observed monitoring typically would focus on instances of noncompliance only. Quarterly maintenance checks were conducted by the fabrication technicians. Maintenance tasks were generally identified and completed when possible during these checks. Additional maintenance requests were addressed via work orders. There was a	

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		database used to track all maintenance activities. Seat bottoms/cushions were inspected by the monitoring team for the following individuals for cleanliness and condition: • Individual #189, Individual #105, Individual #92, Individual #103, Individual #93, and Individual #54. In most cases, these were custom molded systems with a moisture/water resistant material covering the mold and sealed at the seams. In other cases, ROHO cushions were enclosed in a removable, washable cover. The ROHO cushions themselves could be cleaned as needed. Direct support staff received instructions in NEO regarding care and cleaning of assistive equipment, including the wheelchairs, seating systems, and seat cushions. Typically this duty was the responsibility of the night shift, or after meals, toileting, or any other time, as needed, by all staff. A regular plan for cleaning and a regular schedule for maintenance by the fabricator staff should be put in place. Assessments were conducted as needed for new seating systems or for modifications to existing systems. Specific mat evaluations and assistive technology assessments documented this process. There were no assessments conducted during the week of this onsite review. The monitoring team will need to observe this in future reviews, though this process observed during previous reviews appeared to be appropriate. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** PMNP Monitoring forms were used to conduct monitoring by the PNMPCs and addressed availability of plans, required documentation, adherence to the schedule of implementation, use of proper transfer techniques, appropriate positioning, re-positioning as indicated, acknowledgment by staff of training on the PNMP, and entry of information by the monitor in the Monitoring Database. There were 137 completed PNMP monitoring sheets submitted that were completed in the last three months (April 2011 - June 2011). Each was completed by the PNMPCs or technicians. These tools were to be completed for each individual per an individual monitoring schedule established by the Habilitation Therapy department. As described above, this was based on risk but was not established by the PST in conjunction with the health risk assessment process in place. Forms completed were April (50), May (47), June (33), and undated/no name (7). **Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the**	

#	Provision	Assessment of Status	Compliance
		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. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** There were 62 individuals who were monitored one time during this three month period. Monitoring occurred for 16 individuals two times, and 12 individuals three times. Spreadsheets identified the scheduled frequency of monitoring for individuals for those months. Monitoring sheets for a sample of 27 individuals who were scheduled for monthly monitoring as of April 2011 were reviewed. Only 67% of these individuals were monitored per the established schedule. Another spreadsheet was submitted titled Trial PNMP Risk Monitoring 2. There were 19 individuals identified at highest risk and designated for monthly monitoring, 12 times per year. It did not appear that these risk ratings correlated with the risk levels assigned by the PSTs. Of those 12 individuals, three had not been monitored even once during this three month period (April 2011 – June 2011). These included Individual #161, Individual #84, and Individual #94. Individual #8 had been monitored only once and five others had been monitored in only two of the three months. The clinicians are commended for their efforts to develop this system for monitoring, but clearly it is a work in progress. The findings of only the forms with names and dates were analyzed by the monitoring team. Approximately 56% of the forms documented a "no" on one or more indicators. A variety of issues were identified, such as assistive equipment not being available, or assistive equipment needing repair. Immediate issues were to be addressed at the time of the monitoring. Upon completion of the monitoring, the information was entered into a database. There was a system of analysis of the completed forms conducted in a meeting held monthly. At that time, findings were tracked per individual as well as per monitor to identify issues that may need to be addressed. This also served as an ongoing review and training format for the PNMPCs. **Standard: A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.**	

#	Provision	Assessment of Status	Compliance
		There were no policies or guidelines to address the monitoring process, though procedures were in development, as described above. Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. At that time, additional follow-up or training was provided as well as follow-up as indicated in addition to annual re-validation. These were scheduled, but it was not clear how consistently this was conducted. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** The PNMPCs were directed to enter their findings in the database on the computer. In many cases, it was reported that an identified problem had been addressed by the monitor. The form itself did not have a clear place to document actions required and taken to ensure resolution with timetables of completion. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** The intervention plans submitted (SPOs) typically were reviewed on a monthly basis. However, as described above most did not present appropriately written and measurable outcomes with performance criteria. As identified in the previous review, most of these would be met if the individual completed the behavior one time. **Standard: Data collection method is validated by the program's author(s).** There were no SPOs submitted for review that required data collection by direct support staff or validation of implementation and documentation this time.	

Recommendations:

1. Consider audits of assessments, progress notes/program changes and other documentation to examine for consistency and content across clinicians. Ensure that there is a clear mechanism and documentation trail to close the loop on open issues or concerns and track actions through to completion (P1).

2. Consider a reference to the baseline/comprehensive assessment and updates in subsequent updates. In other words, the therapist should clearly cite the date of the previous assessment in the current one. It may make sense to maintain the comprehensive assessment with the subsequent updates in the active record until a new comprehensive was completed. Clear statements as to when the next assessment or

update was to be completed should be included in the recommendations (P1).

3. Consider the integration of risk information in the NEO training when revising the content to address demonstration as described in the POI (P3).

4. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).
    a. A temporary shift in focus from assessment to action and implementation to address the intense need for active treatment may be necessary. Working with the home and day program environments on a day to day basis rather than merely referring or making recommendations promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition (P2).

5. Integrate direct and indirect supports into the PSP through the development of SPOs that include measurable goals with performance criteria. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures as well as functional health status indicators are used to justify initiation, continuation, and/or termination of interventions (P2).

6. Consider the strategy of observation rounds with professional staff, technicians and PNMPCs to conduct drills for additional training for PNMPCs and to assist staff in recognizing when realignment is indicated (P3).

7. Establish a formal curriculum and competencies for training the PNMPCs (P3, P4).

8. Ensure that the new fabricator is provided opportunities for continuing education and to visit other SSLCs in order to provide the knowledge and skills needed to appropriately provide this service (P1).

9. A regular plan for cleaning and a regular schedule for maintenance by the fabricator staff should be put in place (P4).

10. Review the methods used to analyze databases and spreadsheets to ensure accuracy of calculations of compliance (P4)

11. Review the existing OT/PT assessment format to address the sequence of sections to address flow and redundancy. While the integrated summary was a useful aspect of clinical analysis, it was not sufficient to establish the rationale for the recommendations. This may provide a framework of how to design more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports. 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, services and interventions were indicated. These should then be listed as recommendations. Consider changing the name of the summary to analysis as this section should be more than a mere summary of the data (P1).

12. All preparation for the subsequent onsite review should be directed by the Department Director with key professional staff to address content areas. The strategic action plan should drive the activities of all staff and routine review of the status on all action steps should be conducted frequently. The development of the POI should be clearly related to activities conducted to assess status based on chart review observations,

training drills, and so forth, and the actual implementation of actions in the strategic plan with documentary evidence. These should be reported in the POI and serve as the foundation for the assignment of compliance or noncompliance status by the facility. The document request should be put together in a thoughtful, organized manner and if there are questions as to what is being requested, the Director should seek clarification (P1-P4).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o EPSSLC Policy and Procedure: Facility Operational Dental Services Policy, 5/1/11 o Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Presentation Book, Dental o Dental records for the individuals listed in Section L o Desensitization plans for the following individuals: • Individual #25, Individual #28, Individual #17, Individual #21, Individual #92, Individual #57, Individual #18, Individual #169, Individual #89, Individual #117, Individual #74, Individual #27, Individual #128, Individual #11, Individual #6, Individual #53, Individual #1, Individual #65, Individual #15, Individual #67 o Emergency Treatment documentation for the following individuals: • Individual #8, Individual #111, Individual #157Individual #31, Individual #37, Individual #39, Individual #76, Individual #77, Individual #83,Individual #127, Individual #119, Individual #42,Individual #47, Individual #52, Interviews and Meetings Held: o Howard Pray, DDS, Contract Dentist o Russell Redell, DDS, DADS Dental Services Coordinator o Raquel Rodriquez, RDH o Ascension Mena, MD, MS, Medical Director o Carmon Molina, Associate Psychologist Observations Conducted: o Dental department o Informal observation of oral hygiene regimens in residences
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated 7/1/11. The POI did not actually indicate what activities the facility engaged in to conduct the self-assessment. The presentation book for this provision included a number of random audits completed over the past six months. The audits were completed with a tool developed and provided an indication of compliance with specific provision items. The POI did not provide any information related to these audits. The facility rated itself noncompliant with both provision items and the monitoring team concurred with

	these ratings. An action plan was included in the POI. Action steps included items, such as "provide individuals with annual exams on site" and "provide individuals with routine comprehensive exams." It would appear that these action steps were actually the desired outcomes and that what is needed is a series of steps that details how this will be achieved and monitored for substantial compliance with this provision.
	Summary of Monitor's Assessment: The Dental Department continued to make small incremental gains in progress in some areas. A new database was implemented to allow for collection of data to determine progress within the department. This database provided information that was not previously readily available. While the facility was providing significant preventive services, there appeared to be a lack of other care, such as restorative services and x-rays. A troubling finding was the data reported on oral hygiene status which indicated that approximately 40% of individuals had poor oral hygiene. Several steps had ben taken to address oral care provided in the homes, but a lack of quarterly hygiene ratings did not allow for determination of overall interval improvements. Overall, it appeared that annual assessments were being completed in a timely manner, but data integrity issues made it impossible to determine an accurate compliance rate. The facility reported no missed appointments and no shows. This was largely due to the commendable efforts of the two hygienists who frequently escorted individuals from home to the clinic. Several individuals were identified as needing desensitization plans. The plans as developed by the psychology department were not based on the individual needs of the individuals who required the plan. Further, most plans had not been implemented and requests for updates were not fulfilled.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this	Dental services were available five days a week. A contract dentist worked 32 hours per week and provided services on Mondays, Thursdays, and Fridays. Two hygienists continued full time employment in the clinic in addition to the new dental assistant. <u>Provision of Services</u> A new database was implemented in January 2011 and its use was an improvement that allowed the department to track key data related to the provision of dental services. Data generated by the database showed the following types of services were provided:	Noncompliance

#	Provision	Assessment of Status	Compliance
	Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.		

December 2010 – June 2011	
Type of Visit	Number of Clinic Visits
Preventive	269
Annual Assessment	73
Restorative	1
Emergency	24
Extractions	4

Record reviews indicated that most individuals were receiving routine preventive dental care. The facility provided essentially no restorative care during the six months prior to the onsite review. Documentation showed one filling was performed during that timeframe.

Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. A list of 14 individuals had 24 clinic visits for emergency treatment. Based on the summaries and progress notes provided, it appeared that initial treatment was adequate and appropriate. Documentation of resolution was not provided for all 24 visits.

Four individuals required extractions. Two individuals were treated onsite and two required treatment off campus. The records indicated considerable delay from the time the extraction was recommended to date of procedure. The two individuals treated on campus had an average delay of seven months.

Documents related to the provision of x-rays services were submitted. This was in response to the request for a list of those individuals who had not completed x-rays required by generally acceptable professional standards of care. The census contained 134 individuals, 15 of whom were edentulous and did not require x-rays.

The documents indicated that 76 of 119 (64%) individuals had x-rays completed while 43 of 119 (36%) individuals did not have x-rays completed. Explanations were requested for those cases in which x-rays were not completed. That information was not provided. In general, the clinic dentist and dental clinic staff reported that behavioral issues and inability to cooperate for exam and treatment presented numerous challenges to treatment.

<u>Oral Hygiene</u>
During the January 2011 onsite review, the facility was tracking poor hygiene ratings, but did not provide aggregate data on the oral hygiene status of individuals living at the

#	Provision	Assessment of Status	Compliance
		facility. A spreadsheet containing the current oral hygiene status for each individual was submitted. In addition to this, the dental department provided oral hygiene data for the calendar year 2010. It should be noted that the data provided included the 15 edentulous individuals, all of whom had good oral hygiene, as expected. Data, adjusted for dentate status or removal of edentulous individuals, is summarized along with the 2010 and current hygiene ratings the table below:	

Hygiene Rating	2010 Oral Hygiene %	2011 Current Oral Hygiene %	2011 Edentulous Adjustment Oral Hygiene %
Good	21	20	9
Fair	34	37	42
Poor	40	38	43
Not Rated	--	5	6

This data indicated that a significant percentage of individuals had poor oral hygiene in 2010 and current data did not show any substantial improvement. Data, adjusted for dentate status or removal of edentulous individuals, indicated that nine percent of individuals with teeth had good hygiene while 43% of the same population had poor oral hygiene.

Given the facility reported low rates of missed appointments, no shows and refusals, it was apparent that failed appointments were not a significant issue. Behavioral issues and refusals presented barriers to the provision of adequate care. Pretreatment sedation, TIVA, and desensitization were methods used to overcome these barriers and are discussed further in Provision Q2. The dental clinic staff indicated that the provision of oral care in the homes continued to be problematic.

In response to the request for corrective action plans to address the facility's oral hygiene ratings, the facility's POI was provided:

- In February 2011, comprehensive oral hygiene training began in the homes.
- In April 2011, nursing staff received training on the use of suction toothbrushes.
- In May 2011, staff received competency-based training of Dental Services Policy.

In addition to these steps, there were plans to develop a new system to train newly hired staff as well as to complete annual training for all nursing and direct care staff through the iLearn Program.

See Recommendations #1 to #5.

#	Provision	Assessment of Status	Compliance
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.	<u>Policies and Procedures</u> The Dental Clinic revised its local policy to be consistent with state issued policy. The policy was disseminated and staff completed competency-based training. The state dental services coordinator had plans for monitoring and assessing the dental staff's knowledge of policy and procedure. <u>Annual Assessments</u> In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months and the date of previous annual assessment was requested. The documents provided contained a list of assessments beginning in January 2011 along with the dates of the previous assessment. Seventy-six annual assessments were reported. Several of the entries included comments such as "uncooperative," "several attempts," and other comments that indicated, but did not definitely state, that the exam was not completed. Comparing this document to the preventive care/annual assessment report, it was noted that some of the assessments included in the spreadsheet were likely not completed. The exact number of annual assessments completed was not clear, but it appeared that approximately 70 annual assessments were completed during the six month period. <u>Emergency Care</u> Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. A list of 24 individuals who sought emergency treatment 24 times was provided. Based on the summaries and progress notes provided, it appeared that initial treatment was adequate and appropriate. Documentation of resolution was not provided for all 24 visits. <u>Dental Records</u> The dental records were comprised of a medical history, initial/annual exam, treatment plan record, dental health status summary, annual dental summary, and entries into the integrated progress notes. The Health Care Guidelines required documentation in the integrated progress notes. The dental staff documented in the integrated progress notes and notes were appropriately signed and dated. The entries in the progress notes were not completed in SOAP format as required by the Health Care Guidelines. <u>Failed Appointments</u> Multiple documents were provided that contained data related to clinic appointments. Total numbers were provided for each category. The comments section in the annual assessment spreadsheet included notes such as "uncooperative." In cross-referencing	Noncompliance

#	Provision	Assessment of Status	Compliance
		documents, it was not clear that the numbers generated represented the actual number of completed appointments. Data indicated that there were no missed appointments or no shows. The dental hygienist actually went to the homes to escort individuals to clinic appointments. There were 16 episodes of refusals that involved 12 individuals. <u>Restraints</u> At the time of the January 2011 onsite review, the facility had suspended the use of pretreatment sedation on campus due to the medical' director's concern about safety. Individuals requiring sedation and/or anesthesia were treated off campus. The use of pretreatment sedation was resumed in March 2011. From March 2011 to June 2011, 41 individuals received pretreatment sedation 46 times. This number included 11 episodes of sedation that occurred off campus in December 2010. The facility did not offer TIVA at the time of the onsite review, but anticipated starting that program in the near future. The facility had a process in place for identifying individuals in need of desensitization plans. Copies of 19 plans were provided. The plans were developed by the psychology department, but did not appear to have any correlation with a functional assessment of the individuals. In fact, the plans showed no variation or individualization for the specific individuals. In addition to requesting copies of desensitization plans, the monitoring team also requested documentation of the status of each individual's plan. Five status reports were submitted. Of these five individuals, two had achieved some success in having oral hygiene care provided in clinic. During a discussion with the state dental coordinator, contract dentist, dental hygienist, and psychology staff, the psychologist indicated that the psychology department did not have staff adequate to effectively develop and implement 20 desensitization plans. The monitoring team suggested that a system of prioritization be developed and that appropriate and adequate plans be developed for those most in need.	

Recommendations:

1. The facility should refine data collection to ensure that data regarding actual completion of appointments is accurate. Reports should clearly indicate that an appointment was not completed as opposed to using single terms such as uncooperative and third attempt (Q1).

2. The facility must determine if additional restorative services are indicated. If indicated, barriers should be identified and strategies implemented to allow for a greater variety of services to be provided (Q1).

3. The facility should ermine if additional x-rays are required and what if any barriers are preventing this from occurring (Q1).

4. The facility should determine if delays in treatment are a systemic issue and take appropriate corrective actions (Q1).

5. Oral hygiene data should accurately reflect the facility's status particularly given the current high rates of poor hygiene. In addition to determining hygiene status, adjusted data should also be reviewed. This simply requires removing the ratings for those who are edentulous (Q1).

6. Documentation in the IPN must comply with the Health Care Guidelines, which required the use of the SOAP format (Q2).

7. The facility must devote greater efforts to the issue of desensitization. Consideration should be given to developing a system for prioritizing the development of plans. Those persons who are most in need of desensitization plans should have appropriate and adequate plans written and implemented. Additionally, the progress of the plans should be carefully monitored by the PSTs and corrective action taken when the plans do not appear to provide acceptable results (Q2).

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 EPSSLC Organizational Chart o Current Census By Home o Admissions Activity 1/1/11 – 6/16/11 o Staffing data (5/31/11) o AAC Services Policy #16 (10/07/09) o Section R Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication Guidelines o Continuing Education documentation submitted o Current list of Speech staff o The Communication Matrix materials from the author's (Charity Rowland, PhD) website and provided by Mary Mooney, MS, CCC-SLP onsite o Augmentative and Alternative Communication Evaluation and Speech-Language Communication Evaluation template o EPSSLC Speech Language Communication Comprehensive Assessment Instructions o PNMPs submitted o NEO training handouts and test related to communication, AAC and hearing loss o AAC refresher training handouts and test o General Inservice Guidelines on the Utilization of Communication Books o General Instructions for Sign Boards o General Individualized Augmentative Communication Book Instructions o List of Individuals with Behavioral Issues and Severe Language Deficits o List of Individuals with PBSPs and Replacement Behaviors Related to Communication o Assessment schedule o SLP Master Caseload and Priority Plan (11/24/10) o Speech–Language Evaluation Instructions o List of Individuals with AAC o AAC-Alternative Communication Monitoring Form (Strategies for Optimal Communication) o Augmentative Communication System Monitoring Form o PNMP Optimal Communication Strategies (draft of competencies based on Communication Bill of Rights) o PBSPs for the following individuals: Individual #114, Individual #72, Individual #178, Individual #115, and Individual #8 o AAC Special Review Referral Consult for Individual #191 and Individual #116 o Communication evaluations and PSPs: • Individual #66, Individual #152, Individual #84, Individual #82, Individual #73, Individual

	#161, Individual #67, Individual #89, Individual #107, Individual #184, Individual #42, Individual #80, Individual #157, and Individual #44 o Information from the Active Record including: Personal focus Assessments, PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, Annual Medical Summary and Physical, Active Problem List, Hospital Summaries, GI Consults, Orthopedic consults, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab I included Communication assessments and updates), Nutrition tab and PNMP tab for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o PNMP section in Individual Notebooks (included communication books and dictionaries) for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o Mealtime Observation/PNMP monitoring sheets for last six months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #191, Individual #16, Individual #178, Individual #154, Individual #54, Individual #72, Individual #2, Individual #71, Individual #114, Individual #39, Individual #93, Individual #115, Individual #1, Individual #21, and Individual #8. o Assessments, SPOs, and other documentation related to speech treatment for Individual #56, Individual #63, Individual #50, Individual #39 and Individual #172. **<u>Interviews and Meetings Held</u>:** o Anderson Hicks, OTR Habilitation Therapies Director o Henry Kielb, MA, CCC/SLP o Karin de la Fuente, MS, CCC/SLP, o Mary Mooney, MA, CCC/SLP o Bahola Puentes Polo, MS, CCC/SLP o Speech technicians o PNMP Coordinators o Various supervisors and direct support staff **<u>Observations Conducted</u>:** o Living areas o Dining rooms o Day Programs o Workshop

	o NEO training
	Facility Self-Assessment: EPSSLC submitted its self-assessment for this provision (POI), updated on 7/1/11. In addition, the monitoring team requested that the Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements, or the status of a variety of tasks since the previous review in January 2011. The correlation of these tasks to each provision was not always clear. Also, there was no mechanism to determine how the facility had determined noncompliance with each element in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication Guidelines self-audit tool was included in the Presentation Book, but no completed audits or analyses of audits completed in the last six months were included. It was reported that speech technicians were completing these and had prepared the Presentation Book. A list of Action Steps were included in the POI, but were not related to a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. The only action step listed as completed was the investigation of the effectiveness of a Speech-Language Pathologist Assistant with the Assistant Director of Administration. The start date for this action was 4/15/11 and projected completion date was 6/30/11. The evidence was a SLP-A job posting. By report of Anderson Hicks, OTR however, the ADOA did not approve this position. Each of the other 21 action steps listed was identified as in process, though five of these had exceeded the projected completion dates established. This approach appeared to merely document completion of tasks rather than to serve as clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be shorter-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. Example action steps stated: • Develop AAC competency-based staff training program (10/31/11 completion date) • Train staff on the use of AAC program (12/31/11 completion date) These were essentially redundant statements from the Settlement Agreement provision items and did not offer any specific steps or actions to make that happen. The monitoring team concurs with EPSSLC self-assessment of noncompliance for each of the items in provision R.

	Summary of Monitor's Assessment: There was a significant understaffing in this area. Everyone communicates in some way and many require interventions and supports to enhance or augment those efforts and many others would benefit from refinement and expansion for skill acquisition in the area of communication. Though the SLP Master Caseload and Priority Plan was submitted per the request for the state policy-mandated Master Plan, it was essentially only an outline of items for two different time periods and it was not clear how these were related. There were no clear statements of how individuals would be prioritized for the completion of comprehensive communication assessments. The list submitted to the monitoring team related to which and when assessments had been completed, outlined that 60 individuals had completed assessments (each completed since 12/14/10), and all others were identified as pending or assigned. The due dates were generally based on PSP dates, though only 12 individuals who had yet to receive an assessment had due dates identified on this list. Completion of assessments, with 100% completed by 7/1/12 or one year of PSP date, was not unreasonable. Some of the assessments had discontinued the communication books because they were deemed to be inappropriate or non-functional, though in some cases, there was nothing provided as an alternative. Of the 12 individuals who had additional adaptive equipment, there were seven with talking photo albums, most of which had been already in place one year ago. Thus, it appeared that the new assessments were not resulting in additional supports related to AAC and communication. In other words, the number of individuals with AAC had remained essentially the same over the last year. Even though the clinicians should be commended for conducting careful reviews of existing systems to determine if they were appropriate, a more creative approach to the identification of additional AAC systems for others is needed. There were a small number of community-based systems finally mounted after they had been pending nearly one year ago. However, staff indicated that they had only been installed weeks prior to this onsite review. Staff training and actual use appeared to be spotty. There were seven individuals listed as receiving direct speech services, but no current SPO or related documentation for interventions was submitted for review. There was no evidence of routine contact, review, and intervention with the individuals identified as receiving these services. The response to the document request for this provision was not well-organized and in many cases the information requested was not provided and/or a tremendous amount of unrelated documents were submitted. It did not reflect well on the department. There was limited progress noted since the previous review, though it was evident that the speech clinicians were extremely busy with assessments and attempts to organize their approach to achieving substantial compliance. As previously noted, a focus on engagement in functional activities designed to promote actual participation, making requests, choices and other communication-based activities, using assistive technology, was a critical priority. This will require that the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and

	groups across environments and contexts.

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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, there was one full time SLP (Henry Kielb, MA, CCC/SLP) and three part time contract SLPs (Karin de la Fuente, MS, CCC/SLP, Mary Mooney, MA, CCC/SLP and Bahola Puentes Polo, MS, CCC/SLP). There was one unfilled position for a speech language pathologist. There were two full time speech technicians. EPSSLC did not document appropriate qualifications for licensed SLPs (proof of current license) and/or continuing education for each clinician in the last 12 months. Professional credentials were not submitted, so the current status of licensure for these clinicians was not verified at this time. CVs were not submitted for any current speech staff. Evidence of attendance for communication-related continuing education since the previous review was submitted for only one of the current staff (Mary Mooney, MS, CCC-SLP). Though by report, the clinicians indicated that they had participated in an online self-study course, Introduction to AAC, sponsored by the American Speech and Hearing Association and they planned to attend another AAC course on 7/29/11. The POI identified action steps to meet with the Assistant Director of Administration regarding an SLP Assistant. It was reported by the Habilitation Therapy Director that this had been rejected, yet the POI indicated that the action was completed as of 6/30/11. There was no evidence submitted that this position had actually been posted. Further, the POI indicated that a COTA would be hired who had experience with the design of communication plans for individuals with developmental disabilities. This action was of significant concern because an SLP is the professional with the appropriate expertise and license to provide assessment and development of communication plans and supports. While other professionals such as OTs, COTAs, PTs, and PTAs have a role in the design and implementation of communication plans related to position and access, it would be unacceptable to use a COTA, who also did not have the education, training, and license to conduct any assessment and/or design any communication plans. **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.**	Noncompliance

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		The EPSSLC Master Plan was requested. The document submitted was a description of the methodology used to prioritize the completion of assessments. A list of completed assessments was submitted and listed approximately 132 individuals. This list indicated if and when an assessment had been completed, but the priority category was blank for all individuals. Approximately 60 individuals were listed with completed assessments and the other individuals were identified as assigned or pending. Per interview with the speech clinicians, the due dates listed were based on the PSP date rather than priority based on need. This was confirmed via review of 47 PSP dates. Per the Master Plan, prioritization was to be based on completion of the Communication Matrix which was an assessment tool that used "seven levels of communication occurring during the earliest stages of communication seen in typically developing individuals." The resulting matrix provided a printed overview of an individual's communication skills based on interview questions presented to a parent or caregiver. An undated action plan had been developed by the SLP clinicians. It indicated that individuals with a BSP with a communication component would be identified. Next, the SLPs were to screen all individuals for AAC potential who presented at Levels IV to VII in the Matrix, and those individuals who functioned or had demonstrated potential to function with intentional symbolic or abstract language. The third step was to identify individuals at Level VII with increased capacity for language and cognition. The fourth step was the identification of individuals at Levels I to IV for Communication Dictionaries and optimal communication strategies. Finally, the plan was to review all PNMPs with regard to the description of communication to include expressive/receptive language dominance. Each of these actions was to be completed by 6/30/11. This screening was to begin with all April 2011 quarterlies and the PFAs and/or PSPs. Additional screening appeared to be based on reviews of previous communication assessments and dictionaries. It appeared that assessments would be completed per the PSP schedule and that supports and services were to be driven by the findings of the Matrix assessment completed for each individual. The plan submitted documented that 100% of AAC screenings using the Matrix and 100% of Comprehensive AAC assessments would be completed by 7/1/12. This timetable did not reflect an approach that established priorities based on need but rather appeared to merely follow the PSP schedule, and further, appeared unrealistic. A comment dated 12/6/10 in the POI submitted for the previous review in January 2011, 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	

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		independent of the annual PSP. The POI submitted for the current review, dated 7/1/11, stated that the facility planned to develop a tool to assess communication skills and to develop AAC programs with a start date of 4/22/11. The current status was identified as in process. Further a tool was also to be developed to objectively rationalize an individual's communication plan with a start date of 7/1/11. It was of concern to the monitoring team that both the previous POI and the current POI reported plans to develop these tools, but they had not yet been completed. The current projected completion dates were 10/31/11. Based on the documentation submitted, it was not clear as to the status of the implementation of this plan. The current POI also reported that the action step to develop a Master Plan continued to be in process with a projected completion date of 8/31/11, though the lack of a Master Plan had been identified as an issue in previous monitoring reports. The Communication Matrix tool was reviewed by the monitoring team and while it was well-organized and easy to use, it appeared to be based predominately on a developmental approach which suggested that individuals go through specific stages in a specific order and that mastery at one level was necessary before moving to a subsequent level. Assessment based on this approach typically identified at what stage the individual currently functioned and then the goals of intervention were to assist them in reaching the next level or stage. While this may be effective for young children this approach often results in the "teaching" of pre-communication skills , while continuing to leave the adult with communication challenges without a functional means or opportunity to communicate. The functional outcome of communication supports should continue to focus on promoting maximum potential, independence, and participation. An alternate assessment approach examines the quality of the individual's function in relationship to the activities and environments in which they participate or are expected to participate. Observations for assessment are made within the context of the daily routine and interventions also occur within that context. The focus should be on those activities that the individual is currently involved in and the goals are identified based on their functionality and meaningfulness to the individual. They are individualized and are aimed to improve the quality and quantity of participation in activities and routines. This is generally a more effective approach because skills are learned in the natural environment and each of the natural communication partners, such as direct support staff and day program staff are involved in the interventions. An important step in this process is to identify the specific activities in which the individual participates or were considered to be important to participate in. A task analysis of the component steps would further identify those in which the individual could participate more fully. For example, during tooth brushing provided for an individual, they could participate more fully by holding a tooth brush as they move into the bathroom for this activity. Another	

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		individual may participate in gathering the supplies required even though he may require assistance from staff for bathing. Another individual may be able to use a voice output device to choose between two drink choices at a meal. The Communication Matrix may be a useful tool to assist the clinicians in the establishment of a system to prioritize the order of comprehensive assessments, but should be used with caution in isolation to drive decisions about who would benefit from AAC. A spreadsheet submitted listed approximately 131 individuals and included AAC equipment that had been provided as follows: • Communication Book (115) • Communication Dictionary (131) • Talking Photo Album (12) • Two button output device (1) • Go Talk 20+ (1) • Hip Talker (1) • Communication Picture Board (1) • SOMA Sensory AAC device (1) Only 19 individuals had a system in addition to the book and/or dictionary, though at least five of these were related to environmental control rather than communication-based systems. This was a net increase from that documented during the previous review, but was essentially unchanged from the information provided by the facility during the review conducted one year ago. Previously it was reported that approximately 84-90 individuals living at EPSSLC were nonverbal and it was assumed that this remained an accurate reflection at the time of this review. Many of these individuals would potentially benefit from AAC and/or communication supports and services. In addition, there were a number of individuals who were identified as verbal but were described as having limited functional communication skills. They too would potentially benefit from communication supports and services. Per the current documentation, only seven individuals received some level of direct services, including four who were functionally verbal and participated in a writing group. Supports for the other three were focused on the expansion of sign language use. This again was essentially unchanged from the previous review. Clearly not all individuals who would benefit from AAC had been provided it. There were a variety of single message wall switches installed in several homes (506, 510, and 512, for example) and the workshop. As previously noted in the last two reports, installation of these devices had been pending for at least one year. While they were now installed, it was reported that they had only been installed a couple of weeks	

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		prior to this onsite review. Some staff reported that they had been trained regarding these devices, but it appeared that they were not used routinely. For example, the workshop staff stated that they had been busy and they had not used the greeting switch. Records of 15 individuals were requested. There were communication evaluations submitted for 14 of them, though the assessments submitted for Individual #115, Individual #21, and Individual #178 were not current within the last 12 months. No communication assessment was submitted for Individual #191. There had been a dysphagia assessment completed on 1/10/11 that only briefly reported he was a functional verbal communicator, but there was no analysis of his communication needs documented and it did not qualify as a comprehensive assessment. However, an AAC Special Review Referral Consult report dated 6/9/11 was submitted. This was more thorough, but was not of the format presented in the comprehensive communication assessment template. Assessments related to individuals participating in direct speech therapy and the five most current assessments were requested for each clinician. In response to these requests, assessments were submitted for 16 additional individuals. Of the total number of assessments submitted, at least 91% (31 of 34) indicated that the individuals presented with severe communication deficits. Three individuals (Individual #191, Individual #172, and Individual #56) were reported to be verbal with effective expressive and receptive communication skills. The format of each was inconsistent with the template submitted, primarily related to the AAC section and particularly for assessments completed before March 2011. The thoroughness of the content presented varied from clinician to clinician. In each case, the clinicians provided strategies for staff to use to enhance existing skills rather than skill acquisition, though these also varied greatly in content. For example, the strategies offered for Individual #71 were extensive while those for Individual #54 were limited to the use of hand over hand assistance and a show, tell, and touch sequence when interacting with him. As all individuals had yet to receive the current comprehensive assessment, it was not likely that all had been provided the communication supports they required. The clinicians reported that not all individuals had been provided these supports to date.	
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	**All individuals in need of AAC are identified as being in need of AAC.** The most current assessments were significantly improved since the previous reviews and some of them reported an interdisciplinary approach that included OT, PT and SLP (Individual #154, Individual #107 and Individual #72). In some cases, however, the rationale and recommendations did not consistently reflect a careful and thoughtful	Noncompliance

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	identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	consideration of AAC systems, skill acquisition potential, and the consideration of learning opportunities designed and directed by the speech language pathologists. Some examples included:, • Individual #71: His current system was reviewed by a PT and OT and was deemed to be inappropriate as related to his cognitive, motor, and visual skills. The specific system was not described other than it was composed of abstract and picture icons. It was of concern that this system had been in place for him since the previous annual assessment, yet it had not been determined that it was inappropriate until the time of this subsequent assessment. It was reported that due to his limited ability to learn new information and limited initiation with interactions and movement, it was identified that his potential for skill acquisition was guarded. This appeared to be based on his upper extremity use and there had been no discussion of his potential for other access, such as his head, cheek, chin, or lower extremities. Recommendations were limited to instructions for direct support staff to offer choices using tangible objects and that the SLP would meet with Program Developer to integrate a single message switch into his current active treatment. There was no evidence that these supports would be directed and monitored by a speech professional. • Individual #107: His current system was reviewed by a PT, OT, and SLP and was deemed to be inappropriate as related to his cognitive, motor, and visual skills. This system was not described and there was no discussion that other systems had been explored or considered. The recommendations included continued use of the communication dictionary and picture wallboards already available to him. There was no evidence that the use, relevance or effectiveness of these was evaluated in any way. **Standard: Communication Assessment addresses:** • **Both verbal and nonverbal skills** • **Expansion of current abilities** • **Development of new skills** • **Whether the individual requires direct or indirect Speech Language services and** • **The need for further assessment in Augmentative Communication.** The current communication assessment format generally addressed both verbal and nonverbal skills, and expressive and receptive language skills. Each of the assessments in the new format had recommendations related to whether direct therapy or AAC was indicated. The recommendations provided typically addressed staff strategies to use or enhance existing skills, but recommendations related to acquisition of new skills was limited based on the assessments reviewed. Some examples included the following:	

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		• Individual #39: Recommended direct therapy for sign language use • Individual #72: Recommended a Talking Photo Album • Individual #16: Recommended an SPO to make a drink request and inservice training for direct support staff • Individual #56: Recommended writing group. • Individual #172: Recommended writing group • Individual #50: Recommended "work" with speech related to use of sign language • Individual #63: Recommended speech therapy to address sign language • Individual #66: Recommended speech consult services for the development of a talking photo album • Individual #71: Recommended that speech meet with Program Developers to integrate a single message switch into his current active treatment. Specific skill acquisition outcomes were not delineated in the assessments and specific measurable goals were not noted in the documentation submitted for any of the individuals listed above. Other recommendations involved instructing direct support staff to provide tangible objects for manipulation during routine activities, use of picture books, picture wallboards to "maintain or expand" an individual's level of communication skills, or indirect and direct speech therapy consultative services "as needed." While all of these recommendations represented improvement in the assessments reviewed, each of these individuals had previously been receiving the same or similar services and no recommendations for additional individuals were noted. In addition, the implementation of communication-related activities required SLP modeling, coaching, support, training, and monitoring rather than merely a written recommendation in the annual assessment. SPOs and documentation were requested for the following individuals identified as currently participating in direct speech therapy (Individual #56, Individual #63, Individual #50, Individual #172 and Individual #39). None was submitted related to intervention provided in at least the last six months. **Standard: If receiving services, direct or indirect, the individual was provided a comprehensive Speech-language assessment at a frequency that ensured relevance and appropriateness of goals.** There were only seven individuals listed as receiving direct speech services and the documentation for five of those were requested for review. As stated above, no documentation was submitted related to current therapy supports or interventions. There were no measurable goals stated for any of these individuals or for the four others	

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		listed above. None had goals/objectives/outcomes written, and none were followed by the SLP on a monthly basis if service was direct, or quarterly if indirect. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** It was previously reported in each of the monitoring team reports that the writing group conducted by the SLP did not incorporate functional, measurable goals for the participants and, as such, should not be considered a training objective. Individual #56 and Individual #172, for example, had participated in this group at least prior to 4/15/08 to the present time. There was no evidence of goals and documentation to identify their progress in this group. It was of significant concern that despite this being identified numerous times as a concern for several individuals in this group, nothing had changed regarding this issue at the time of this current review. **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. Communication programs are integrated into the PBSP as indicated.** Of the 15 individuals selected in the sample, there were five identified with behavioral issues and severe language deficits (Individual #178, Individual #72, Individual #114, Individual #115 and Individual #8). None of the records reviewed (0 %) reflected appropriate integration of the communication program and the PBSP. Examples of individuals with identified communication difficulties whose plans were not integrated in the PBSP: • There was reference to Individual #115's communication book related to desired replacement behaviors in his BSP. His Communication Assessment was dated 5/26/10, though a more current assessment was listed as completed on 5/20/11. This was not included in his individual record. It could not be determined if this more current assessment reflected any changes in his needs for communication supports that should be included in his BSP. In addition the most current PSP present in his record was also not current, dated 6/1/10. • Individual #8's communication assessment referred to a BSP that was nearly one year old at the time the assessment was completed. At that time, it was reported that the BSP included use of the communication book, but as he did not attend to it, the SLP suggested that non-language based forms of communication be used with him as described in a section of strategies for optimal communication. The SLP, however, continued to state that the book should be	

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		used and was included as a recommendation. Further, it was reported that the SLP had a concern that staff were directed in the BSP to provide verbal counseling related to the dangers and consequences of his behavior. The SLP indicated that Individual #8 appeared to show no significant comprehension of language and this would be ineffective. It was noted in the BSP dated January 2011 that again the communication book was referenced as a means of expressive communication for Individual #8. There were a number of alternate behaviors identified in the BSP, such as object manipulation, taking a walk, picking up trash, chores, shower, or massage with a personal massager. These would be ideal activities to include as signs, on a single message switch or in photos, for example, yet there was no evidence that these had been considered as additions to his communication plan. The communication book submitted included only a handful of signs that were duplicated in each of the books for other individuals (eat, drink, more, towel, wash hands, and bathroom). There did not appear to be effective integration between the SLP and psychology in the development of his BSP and communication plans. Training objectives included in his PSP dated 12/9/10 addressed the identification of coins by pointing and to identify an exit sign using a flashcard and that he would sign in to workshop by connecting the dots to complete the initials of his first and last name. These did not appear to be meaningful and functional for him, yet there was no evidence of a functional skill acquisition plan related to communication or collaboration by speech and psychology to design more appropriate programming. • An assessment for Individual #114 was dated 10/19/10. He was identified as a nonverbal communicator and he was listed with a BSP. There was no reference to his BSP in this assessment. A new assessment was pending with no established due date. His communication book was to be discontinued with recommendations for an AAC system that incorporated tangible objects and a large switch to activate a lava lamp that he appeared interested in. The stated purpose of his BSP, dated December 2010, was to increase his use of communication skills and to decrease aggression and self-stimulatory behaviors. There was no reference to the communication assessment strategies and recommendations and no evidence of collaboration in the development of either the behavior or communication plans. Individual #114's PSP was dated 11/9/10, though the PST agreed to the recommendations of the SLP per the documentation, there were no training objectives related to communication. There was no policy related to the identification of behavioral challenges and related communication deficits. Lists were submitted as requested of individuals with communication-related replacement behaviors in their PBSPs (46) and also for individuals who had behavioral concerns and severe communication/language deficits	

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		(73). The assessment used for those who received behavioral supports (89) was the same used for other individuals living at EPSSLC. Only 42% of those individuals with a BSP had a communication assessment completed since 12/14/10, and many of these would not be considered comprehensive, particularly if completed prior to March 2011. Compliance in this area would not be possible by merely describing the PBSP (some of the BSPs referenced were not current) in a section of the communication assessment. Collaboration between SLPs and psychology related to assessment and analysis of associated communication and behavioral concerns, as well as in the development and implementation of related training objectives, would be required. **Standard: Communication programs were integrated into the BSP as indicated.** PBSPs were submitted for 5 of 15 individuals included in the sample reviewed. Each was identified with severe language deficits and three had communication-related replacement behaviors included in their PBSPs. Only three had a communication assessment current within the last 12 months, and only Individual #115 had an assessment in the most current, most comprehensive format. There were no projected assessment completion dates identified for Individual #8 or Individual #115. Without a current comprehensive assessment, accurate and appropriate information related to communication may be unavailable for effective integration into a behavior plan. **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. The Master Plan outlined action steps, but not the schedule of assessments for completion. A separate list was submitted in response to a request for assessments and the dates of completion. As stated above there was a category for priority, but this was blank. The Master Plan as outlined in the policy was intended to prioritize those individuals who would most benefit from AAC devices or equipment. AAC provided to individuals was to be listed in the Master Plan as well. There was no facility policy that outlined the communication assessment schedule, guidelines to prioritize assessments, or that established specific staff responsibilities. There was no evidence that the facility had a Master Plan to guide and prioritize the completion of comprehensive communication assessments. The POI indicated that completion of this plan was targeted for 8/31/11 with placement in a shared folder for PST access by 9/30/11. This plan had been in development for over one year per previous POIs submitted by the EPSSLC. The barriers to completion of this plan were not adequately explained to the monitoring team.	

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		Individuals were to be provided an assessment based on the Master Plan, currently described as based on the PSP schedule. Based on the documentation submitted, each individual living at EPSSLC had received a communication assessment on an annual basis, though only those completed most recently were of a more comprehensive nature. While this was commendable, this schedule continued to limit the opportunity for therapists to spend more hands on time with individuals and direct support staff for the development and implementation of functional communication supports integrated throughout the day and across home, work, and leisure environments.	
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: Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.** Recommendations from the communication assessments were not well integrated into the PSP. Some examples included: • Individual #184: Per the assessment dated 4/13/11, there appeared to be a thorough assessment and analysis of her potential for AAC, though the recommendations included further interdisciplinary assessment, with merely a vague reference to program development. The annual PSP had been conducted on 2/16/11 and, as this assessment had been completed two months later, it was not available to the PST at that time. There was no evidence of a PSP addendum to integrate this information and recommendations. • Though not present in Individual #191's individual record, an AAC Special Review Referral Consult report dated 6/9/11 was submitted in the Presentation Book. This was the result of a referral for assessment related to environmental control and independence. It was not clear why he had not received a comprehensive communication assessment upon admission or at the time of the PSP in February 2011. Recommendations from this consult included installation of a Power Switch for control of radio and television, exploration of assistive technology to change TV channels, provision of listening head phones, exploration of the STAP program to increase telephone access, and a PST meeting to design a plan for independent and functional access to equipment. There was no evidence of a PST meeting conducted for Individual #191 via an addendum since this consult was completed over one month later. **Standard: The PSP contains information regarding how the person communicates and strategies staff may utilize to enhance communication.** • There was no description of expressive or receptive communication skills outlined in the PSPs for Individual #191, Individual #1, Individual #154, and	Noncompliance

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		Individual #54. • Individual #2 was described merely as unable to verbalize her choices, wants, or needs. There was a reference to the communication dictionary, but specific strategies were not offered. There were some limited guidelines for how to communicate with her. • Individual #93 and Individual #114 were described as being nonverbal and though the strategies for optimal communication were referenced in the plan, none of those strategies were outlined. • Individual #21's communication dictionary information was included in the PSP, but other than suggesting hand over hand assistance, the suggestions for staff use to communicate effectively with Individual #21 were absent. • The PSP described how Individual #178 communicated expressively, but there were no guidelines provided as to how staff would most effectively communicate with him. • In the case of Individual #72, specific guidelines for staff were outlined in the PSP, but it was not identified how he communicated expressively. • A very technical description of language testing was reported in the PSP for Individual #39, however, there was no functional or meaningful information available in the plan for staff use. • There was no current PSP in the individual record for Individual #16 or Individual #115. Interestingly, the PSP for Individual #25 was submitted as evidence that the PSPs contained information related to how the individual communicated as well as effective strategies for staff use. There was a statement in the Optimistic Living Vision that Individual #25 was not able to communicate her expectations regarding moving into the community because she was not able to communicate verbally, but there was no description as to how she did communicate. The Speech section discussed her status related to oral intake. It was reported that the team discussed strategies for optimal communication and agreed they should be incorporated into her programming, but none of those strategies were outlined in the plan. The team agreed to discontinue her communication book, but there was no rationale provided. She was to be provided a low tech AAC system, such as a talking photo album, and the communication dictionary and picture wallboards should continue. There was no description of how she used these or if they were effective. The action plan section of the PSP was not presented so it was not possible to determine if any communication-related goals or strategies were included. **Standard: Communication information is not only present in the PSP but integrated into the daily schedule**	

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		As stated above information related to communication was not present in the majority of the PSPs reviewed. There were brief statements related to communication in the PNMPs, but there was no evidence that this was integrated throughout the day. **Standard: AAC devices are portable and functional in a variety of settings.** The majority of systems provided were limited to the communication book and dictionary for approximately 85% of the individuals listed with AAC. Additional systems, such as talking photo books were also portable with the potential to be functional across environments. **Standard: AAC devices are individualized and meaningful to the individual.** As 85% of individuals listed with AAC had only a communication book and/or communication dictionary, they did not appear to be sufficiently individualized and meaningful. In fact, many of the communication books contained the same pictures and icons for a number of individuals. The majority of assessments submitted did not reflect any consideration for the types of icons and pictures relative to size, color, or detail nor was there any discussion of those that would be most functional and meaningful for the individual. In some cases, a book had been in place for at least a year and was discontinued for an individual because it was determined that he or she could not see the pictures. It was of great concern that this had not been considered at the outset in an initial assessment aimed at the identification of appropriate AAC systems. A single message switch mounted in home 510 was described as intended for Individual #108 (a woman) had a picture of a man walking. The message was "I want to go for a walk." **Standard: Staff are trained in the use of the AAC.** Direct support staff did not appear to be knowledgeable regarding communication programs. No communication books were observed being used. A four way device intended for activity requests was present in home 512, however, the device was not working properly. This and other community-based devices had only recently been installed and staff indicated that they had not received training regarding its use. Individual #63 had been provided a Hip Talker, yet it had been left in his home while he was in the workshop. General inservice guideline sheets were included with some of the communication books submitted for the individuals in the sample selected for review, though these were exactly the same for each. There was no evidence that competency-based training had actually been conducted for these or any other AAC systems provided to individuals living at EPSSLC. Some training	

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		sheets were submitted reflecting training on the optimal communication strategies recently added to some of the PNMPs. In some cases, the training sheets merely listed the recommendations from the communication assessment as the information trained. The training sheets should outline the information content needed by and the actual skills expected to be performed by staff. The monitoring team observed a portion of the NEO training provided to staff related to communication. The information presented was highly technical, including a discussion of the levels of the brain and the craniosacral nerves, with a significant amount of technical jargon used throughout. The complex handout provided described the brain centers related to communication and language (e.g., Wernicke's area, base cognition, cerebral artery), but did not provide any functional, meaningful, or useful information for staff to take away and apply to their jobs and everyday routines. There was no information presented to serve as a foundation for more individual-specific training. There would be no way to establish competency for staff to be effective communication partners with the individuals they support via this training. Moreover, some of the training content was not consistent with current standards of practice related to AAC use. When these concerns were shared with the Habilitation Therapies Director, he indicated that he had not observed the training. Other speech clinicians had being working to develop an alternative training related to communication and AAC, but this had not been implemented. **Standard: Communication strategies/devices are implemented and used.** While the general interactions of staff with the individuals they served were generally positive, 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. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. **Standard: General AAC devices are available in common areas.** A number of community-use devices were available in homes 510, 512, 506 and the workshop, for example. These non-portable devices may be useful as a backup or as extra systems for individuals, but should not be used as the primary augmentative or	

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		alternative means of communication for any individual. Moreover, there was no evidence that there were clearly outlined directives on how staff should utilize these general AAC devices. None were observed in use during the onsite review and a number of staff reported that they had only been in place a couple of weeks. Direct support staff were insufficiently trained to integrate informal communication programming throughout the day or to capture those teachable moments that occurred in order to promote communication skill acquisition. As stated above, there appeared to be insufficient time devoted to hands-on training, modeling, and reinforcement of the appropriate implementation of communication supports of any kind, including AAC. There was no evidence of formal communication programs submitted and limited SLP support was available to ensure sufficient supports for appropriate and routine implementation of the recommendations addressed in the communication assessments.	
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: Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.** There were no policies related to a monitoring system for AAC. A form for monitoring the application of strategies for optimal communication had been developed. These strategies were not related specifically to AAC systems, so did not serve to track the presence, working condition, implementation, or effectiveness of the device. This form was completed by a speech tech and, as such, this staff would not be qualified to make judgments as to the effectiveness of communication supports. An additional form had been developed to monitor AAC systems and was again completed by the speech technicians. This form was not completed as designed in a number of cases. For example, in most cases, one indicator stating that observation/data collection of use was marked as yes, yet the subsequent question addressed whether staff had been inserviced in the case that data collection was not correct. The tech also marked this as yes when there was no need to inservice staff on this item. Further, the forms were largely illegible. There was no analysis of the monitoring for use to direct staff training or system change. Many of the forms completed in May 2011 documented that the optimal strategies for communication were not included in the PNMP. Only 19 individuals were monitored during the month of May 2011. Each of these individuals had been provided a communication dictionary and communication book only. None of the individuals with other AAC systems had been monitored during that month. There was no evidence that the speech clinicians routinely reviewed implementation of these systems with regard to	Noncompliance

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		availability, condition, implementation, and effectiveness. **Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.** The monitoring was noted to be completed in the home and workshop areas, but there was no planned schedule to ensure that monitoring addressed all of the environments. **Validation checks are built into the monitoring process and conducted by the plan's author.** There was no evidence of validation monitoring conducted with the speech tech at the time of this review. PNMPCs had not yet been trained to conduct this monitoring.	

Recommendations:

1. Establish a clearly outlined strategic plan to direct the activities of the speech clinicians that will focus on those actions necessary to make progress toward and achieve substantial compliance with each item of this provision (R1-R4).

2. Immediately revise the existing NEO and refresher training curriculum and participant handouts. Alternatives should ensure that staff understand and can demonstrate how to be effective communication partners with the individuals they serve. Content should be functional and meaningful to the critical role that direct support professionals play in the daily routines, communication opportunities, and teaching/learning experiences provided to the individuals living at EPSSLC (R3).

3. 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 (R2, R3).

4. Establish SPOs and ensure there is consistent documentation of interventions in the integrated progress notes and/or as otherwise required via the PSP process (R2).

5. Review and revise the existing system used for staff training to ensure consistency and clarity as to the purpose of person-specific and more general communication-related inservice training for staff. Provide inservice training and monitoring of all speech personnel who conduct this training. Training for community-based systems should include modeling, demonstration and follow-up to ensure that their use is understood and consistent (R3).

6. Initiate meaningful collaboration with psychology in order to develop a plan that ensure appropriate, integrated and comprehensive assessment, program development, staff training and monitoring for individuals with communication deficits and related behavioral concerns (R2).

7. There is an urgent 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. A program of this nature could be especially effective if implemented with OT and PT and/or psychology (R1-R3).
    a. A temporary shift in focus from assessment to action/implementation may be necessary. Working with the home and day program environments on a day to day basis promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition (R1-R3).

8. A system of routine monitoring should be developed to address effectiveness, appropriate use and application of communication programs and AAC systems as well as the condition and availability of materials and/or equipment required form implementation (R4).

9. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs (R3).

10. All preparation for the subsequent onsite review should be directed by the Department Director with key professional staff to address content areas. The strategic action plan should drive the activities of all staff and routine review of the status on all action steps should be conducted frequently. The development of the POI should be clearly related to activities conducted to assess status based on chart review observations, training drills, and so forth, and the actual implementation of actions in the strategic plan with documentary evidence. These should be reported in the POI and serve as the foundation for the assignment of compliance or noncompliance status by the facility. The document request should be put together in a thoughtful, organized manner and if there are questions as to what is being requested, the Director should seek clarification (R1-R4).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Personal Support Plans for: • Individual #10, Individual #67, Individual #161, Individual #184, Individual #80, Individual #13, Individual #183, Individual #69, Individual #154, Individual #72, Individual #172, Individual #84, Individual #157, Individual #42, Individual #61 o Specific Program Objectives (SPOs) for: • Individual #46, Individual #58, individual #125, Individual #120, Individual #75, Individual #21, Individual #129, Individual #66, Individual #172, Individual #118, Individual #12, Individual #164, Individual #10, Individual #77, Individual #183, Individual #69, Individual #13, Individual #80, Individual #184, Individual #161, Individual #61, Individual #36, Individual #67, Individual #56 o Skill Acquisition Plans (SAPs) for: • Individual #118, Individual #76, Individual #73, Individual #189, Individual #104, Individual #109, Individual #155, Individual #54, Individual #2 o Dental Desensitization Plans for: • Individual #17, Individual #65, Individual #117, Individual #74, Individual #92, Individual #18, Individual #27, Individual #53, Individual #169, Individual #25 o SPO data for: • Individual #164, Individual #10, Individual #77, Individual #117, Individual #20, Individual #69, Individual #57, Individual #12, Individual #63, Individual #18, Individual #30, Individual #9, Individual #132, Individual #93, Individual #54, Individual #2 o Quarterly reviews of SPO progress for: • Individual #161, Individual #184, Individual #123, Individual #9, Individual #144, Individual #154, Individual #152, Individual #111, Individual #25, Individual #93 o EPSSLC Plan of Improvement, dated 7/1/11 o Engagement data for Cottages 506 (March, April, and May of 2011), and 512 (April, May, June, and July of 2011) o Active Treatment Minutes, dated 7/11/11 and 7/12/11 o Description of on- and off-campus work sites, undated o List of individuals who attended public school (four individuals) o ARD/IEPs for Individual #81, Individual #69, Individual #35 Interviews and Meetings Held: o Cynthia Martinez, QMRP Coordinator o Janice Chowning, Active Treatment Coordinator

	o Carmen Molina, Associate Psychologist o Lupe Azzam, Mindy Partida, Myriam Valdez, and Susan Abbott, Program Developers o Alex Euzarraga and Rosa Renteria, QMRPs <u>Observations Conducted</u>: 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 submitted its Plan of Improvement (POI), dated 7/1/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the QMRP Coordinator identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of the self-assessment were used to determine the self-rating of each provision item. EPSSLC's Plan of Improvement (POI) indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas. 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 throughout the facility, and because it will likely take some time for EPSSLC to make these changes, the monitoring team recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next 6 months are summarized below, and discussed in detail in this section of the report.
	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, the monitoring team noted several improvements since the last review. These include: • Modifications to the skill acquisition training sheet/format • Expansion of the training methodology • Initiation of graphing of skill acquisition data • Continued focus on improving individual engagement in selected cottages The monitoring team believes that the facility should focus on the following over the next six months: • Ensuring and documenting that SAPs are meaningful to each individual (e.g., based on documented need and preference) • Ensuring that the continuation, modification, or discontinuation of SAPs are the result of data-based decisions • Ensuring that the SAPs are implemented with integrity • Continuing to improve individual engagement by focusing on one cottage at a time

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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. Although there had been continued progress since the last review, as indicated below, more work needs to be done to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision item. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at EPSSLC had multiple skill acquisition plans. Skill acquisition plans at EPSSLC consisted of training objectives, and were referred to as specific program objectives (SPOs) prior to June 2011. The facility has recently changed the format (see details below) and name of these new program objectives to skill acquisition plans (SAPs). To minimize confusion, all skill acquisition plans in this report will be referred to as SAPs. SAPs were written and monitored by four program developers. Program developers were supervised by QMRPs, and SAPs were implemented by direct care professionals (DCPs). As discussed in the last report, an important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Personal Support Plan (PSP), adaptive skill or habilitative assessments, psychological 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/or represent a documented need.	Noncompliance

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		EPSSLC made progress in this area since the last review. The facility modified the SPO (now SAP) training sheet/format to include a rationale for the specific acquisition plans. For example, Individual #69's SAP for money management included the statement that he wants to learn more about adding. The addition of a section to the SAP training sheet that required the rationale for choosing this particular objective is a direct way to ensure and document that SAPs are based on individual needs and preference. The monitoring team cautions the facility, however, to not simply state that all SAPs were chosen because of individual preference. For example the monitoring team observed Individual #189 doing his money management SAP in his residence (Dorm B). The new SAP indicated that it was chosen because Individual #189 wants to be more independent with his money. Individual #189 was nonverbal and did not appear at all interested in the money management SAP. The DCP working with him, and the program developer who wrote the SAP both agreed that Individual #189 did not use money (other than during the SAP), and it was unlikely he really did want to be more independent with his money. Although a rationale for the SAP was included, this SAP did not appear individualized, meaningful to the Individual #189, or represent a true documented need. Once identified, 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 In the last report, the SAPs at EPSSLC did not consistently contain the use of relevant discriminative stimuli, specific consequences for incorrect responses, or a plan for maintenance and generalization of skills. This was another area where the facility had begun to make improvements, by further modifying the SAP training sheet to ensure that specific consequences for incorrect responses were included. For example, Individual	

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		#104's SAP for hand washing stated "when (Individual #104) responds incorrectly, withhold reinforcement and repeat modeling again and providing immediate full prompt of the correct action." None of the SAPs reviewed, however, contained the use of relevant discriminative stimuli, or a plan for maintenance and generalization of skills. It is recommended that all SAPs also include the use of relevant discriminative stimuli, and a plan for maintenance and generalization of skills. Finally, as recommended in the last review, the training methodology at EPSSLC was expanded from the exclusive training of one step of a task analysis at a time, to other procedures shown to be effective in developing new behavioral repertoires, such as forward and backward chaining. At the time of the onsite review, staff were being trained to use the new training methodology. <u>Desensitization skill acquisition</u> Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. A list of dental desensitization plans developed indicated that 19 plans were developed since the last onsite review. Review of 10 of those plans revealed, however, that they were all identical. It is recommended that individualized dental desensitization plans be developed and incorporated into the new SAP format. 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 in future site visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> EPSSLC included replacement behaviors in each PBSP. As discussed in K9, there were no descriptions of teaching conditions, no specific teaching instructions, and it was not clear how, or if, staff were trained to teach the replacement behaviors. Replacement behavior training procedures, like those for the dental desensitization plans, should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. <u>Communication and language skill acquisition</u> The monitoring team did not encounter any acquisition programs targeting the enhancement or establishment of communication and language skills. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs.	

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		Service objective programming Finally, the facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written and monitored by the program developers. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). 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 at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each cottage and day program is listed in the table below. Since the last review, the facility has made several changes to improve active treatment. These improvements included the addition of new activity materials available to DCPs, and the introduction of daily interdisciplinary active treatment meetings focused on increasing engagement in selected cottages. The monitoring team was encouraged to observe more group activities than observed in past reviews. Additionally DCPs stated that they knew how to get new activity materials when they needed them. An example of active group activities was found in cottage 506 (one of the cottages targeted to improve engagement in the Active Treatment meetings discussed above). Individuals were found in small groups throughout this cottage interacting with each other and staff. Nevertheless in the majority of cottages, the monitoring team observed only individual activities that often consisted of dated activities, such as placing pegs in a board and putting together puzzles. The table below documents engagement in various settings throughout the facility. The average engagement level across the facility was 49%, about the same as that observed during the last review (i.e., 50%), and an increase over the first two reviews (36% and 42%). An engagement level of 75% is a typical target in a facility like EPSSLC, indicating that the engagement of the individuals at EPSSLC continued to have room to improve.	

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		Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
Cottage 509	0/5	2:5
Cottage 509	2/3	2:3
Cottage 509	3/4	1:4
Cottage 508	3/7	3:7
Cottage 508	2/7	3:7
Cottage 508	6/11	3:11
Cottage 510	2/7	2:7
Cottage 510	3/7	2:7
Cottage 506	8/8	3:8
Cottage 512	4/4	2:4
Cottage 513	4/4	1:4
Cottage 513	7/7	2:7
Cottage 507	1/5	2:5
Cottage 507	3/6	2:6
Cottage 511	2 /4	2:4
Vocational Workshop	15/15	5:15
Vocational Classrooms	2/6	2:6
Vocational Classrooms	3/6	3:6
Vocational Classrooms	1/4	1:4
Vocational Classrooms	1/4	0:4
Vocational Classrooms	0/2	1:2
Vocational Classrooms	1/3	1:3
Vocational Classrooms	3/3	2:3
Dorm C	4 /12	3:12
Dorm B	3/10	2:10
Dorm B	4/10	2:10
Dorm A	1/7	1:7

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		Educational Services Four 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). One of these four was transitioning to the community, therefore, three individuals were expected to be attending school next year. The monitoring team reviewed ARD/IEP documents for these three individuals as well as spoke with the EPSSLC QMRP who had responsibility as liaison with the public school and a QMRP who was to also be involved with EPISD next school year. The QMRP reported that a positive relationship continued to exist between EPSSLC and EPISD. For instance, Individual #69 missed end of the year middle school graduation due to medical issues and his classroom teacher came to the facility to present him with his diploma and have dinner together. In another case, the QMRP and EPISD problem solved a satisfactory outcome to serious behavioral outbursts exhibited by one individual. EPSSLC participated in students' school meetings and the QMRP incorporated some of the Individual #69's school activities into his EPSSLC PSP action plans (e.g., regarding animals and computers). The positive relationship with EPISD was due, in large part, to the efforts of QMRP Alex Euzarraga. Students attended an extended school year program that ran from the end of the regular school year through late July. The ARD/IEP for Individual #69 showed a large number of instructional objectives that appeared to be relevant to the student's education. The ARD/IEP for Individual #81 showed few instructional objectives, and many of them were worded in ways that did not allow the reader to determine what was going to be worked on, such as "… will master daily living skills with 70% success rate." The ARD/IEP for Individual #35 showed even fewer instructional objectives. The monitoring team requested, but did not receive any reports regarding the progress of the students on their educational objectives. The EPSSLC SAC reported that progress reports were not sent unless they were requested.	
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, the facility was beginning to make improvements in the documentation of how this information impacted the selection of specific program objectives. Overall, however, more work is needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was using the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. DADS was in the process of evaluating several assessments as an alternative to PALS. The monitoring team is supportive of the	Noncompliance

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		identification of an alternative to PALS, and looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology, etc.) and individual preference, to identify meaningful individualized skill acquisition programs. Finally, while the PSP attempted to identify individual 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.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	EPSSLC was making progress on this provision item. More work, however, in the areas of integrity of implementation and the practicality and function of SAPs is needed before this item can be rated as being in substantial compliance. As recommended in the last report, the facility began the graphing of SAP data monthly. Program developers at EPSSLC summarized SAP data monthly, and presented those data at quarterly meetings. Reviews of SAP data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., toileting for Individual #9). Many other SAPs, however, indicated no improvements (e.g., money management for Individual #132, community safety for Individual #20) without any indication of a modification of the plan, retraining of staff, etc. Additionally, SAP data indicated that Individual #152's SAP for self-help and bathing skills were achieved on 5/31/11, the objectives, however, continued to be conducted. The implementation of graphed daily data was an encouraging development at EPSSLC, however, the above examples indicated that the program developers require additional tools to be able to ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data. The skill acquisition plans at EPSSLC appeared practical and functional for some individuals (e.g., teaching Individual #123 to independently use adaptive equipment), however, for many others (e.g., Individual #189 money counting objective discussed	Noncompliance

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		above) it was not clear how or why these plans were chosen. The facility should ensure that SAPs are consistently practical and functional. The monitoring team observed the implementation of SAPs in several day programs and homes during the onsite review to evaluate if SAPs were implemented as written. Additionally, SAP data sheets were also reviewed to evaluate if data were completed as scheduled. The following observations were typical: • Individual #189 was working on his SAP of counting coins. The SAP specified the use of gestural prompting. The DCP appeared to use all hand-over-hand prompting to teach Individual #189 the skill. • Individual #132's money skills SAP specified the use of tactile prompts on the training step, however, the DCP was observed using gestural prompts. • In four of the seven SAP data sheets (57%) reviewed in the homes and vocational sites, data were missing. The results from these observations were discouraging. The only way, however, to ensure that SAPs are conducted as written is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. Finally, at the time of the onsite review, each program developer was responsible for writing and monitoring approximately 350 SAPs. The monitoring team believes that that is too large a caseload to ensure that each SAP is effectively written and monitored. Despite the improvements in this area since the last review, the monitoring team does not believe that EPSSLC will be able to achieve substantial compliance with this provision item until they restructure how skill acquisition programming is organized, implemented, and monitored at the facility.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at EPSSLC enjoyed various recreational activities in the community. The facility had begun to make progress in providing training in the community. More work, however, is necessary for this item to achieve substantial compliance. The facility provided the monitoring team with several examples of training activities occurring in the community (e.g., Individuals #36's identifying the men's room in the community and Individual #56's identifying crosswalks in the community). There was, however, no way evaluate how often SAP training occurred, or how many individual's at EPSSLC had skill training in the community. It is recommended that training activities in community be separately recorded so that community training trends could be better tracked, and increased across the facility.	Noncompliance

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		At the time of the review, no individuals at EPSSLC worked in the community. One individual was reported to work in the community during the last onsite review.	

Recommendations:

1. SAPs should be individualized, meaningful to the individual, and/or represent a documented need (S1).
2. SAP training sheets should include the use of relevant discriminative stimuli and plans for the maintenance and generalization of acquired skills (S1).
3. It is recommended that individualized dental desensitization plans be developed and incorporated into the new SAP format (S1).
4. Replacement behavior training procedures, should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs (S1).
5. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (S1).
6. Program developers need to ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data (S3).
7. Ensure that SAPs are consistently practical and functional for all individuals (S3).
8. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written (S3).
9. It is recommended training activities in community be recorded so that community training trends could be better tracked, and increased across the facility (S3).
10. The monitoring team suggests that the facility restructure how skill acquisition programming is organized, implemented, and monitored at the facility (S3).
11. Document integration of the public school program, including the ARD/IEP, in the individual's PSP.
12. QMRP and/or PST should obtain and review EPISD progress reports for each individual. This review should be documented in the quarterly PSP review at EPSSLC.

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) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, and attachments o DADS Obstacles Report for SSLCs, October 2010 o Organizational chart, undated, but current o EPSSLC policy lists, 4/8/11 o List of typical meetings that occurred at EPSSLC o EPSSLC POI, 7/1/11 o EPSSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/11/11 o Community Placement Report, through 6/13/11 o List of individuals who were referred for placement and had been placed since last onsite review (1 individual) o List of individuals who were referred for placement and had not yet been placed (9 individuals) o Individuals on the referral list for more than 180 days (6 individuals) o List of individuals who requested placement, but weren't referred, 6/13/11 (2 individuals) o List of individuals who requested placement, but weren't referred solely due to LAR preference, 6/13/11 (1 individual) o List of rescinded referrals (2 individuals) and PSPA notes regarding each rescinding o List of individuals returned to facility after community placement (no individuals) o List of alleged offenders (no individuals) o List of individuals discharged under alternate discharge procedures (no individuals) o List of individuals who have died after moving from the facility to the community since 7/1/09 (no individuals) o Log, developed by APC, listing every individual, status of referral, living choices expressed by individual and LAR, CLOIP recommendation, and blank columns for additional information o APC weekly enrollment report, 7/8/11 o Description of how facility assessed an individual for placement o List of all individuals at the facility, indicating that all had been assessed for placement o One page listing of provider fair dates, 7/14/11 o Documentation regarding SSLC and MRA collaboration: email 6/6/11, meeting notes for 1/11 and 2/11 o Documentation regarding central office training for all APCs and PMMs from all SSLCs, 4/6/11; and APCs 6/23/11

	o Documents regarding upcoming training by APC for facility staff, for late July 2011 o Living Options Discussion training session PowerPoint slides o APC and PMM conference calls with central office and other facilities agenda, 2/11 through o Completed CLOIP worksheets from February 2011 through mid-June 2011 o List of upcoming tours of day programs for unnamed individuals for the last two weeks of July 2011, and list of providers visited by 2 of the 9 referred individuals since April 2011 o Listing of all community outings for all individuals for the past year (27 pages); within this listing were the community provider tours, 6/15/11 o Checklist of assessments for CLDP for Individual #14 o DADS central office written feedback on two CLDPs (Individual #14, Individual #164) o Completed self-monitoring tools for Living Options Discussion for Individual #73 and Individual #15, 6/15/11 and 6/29/11 o Blank checklist tool used by APC regarding assessment submissions for CLDP o List of all post move monitoring visits 11/1/10 through 5/26/11 o PST notes and many photos regarding the placement options for Individual #132 o PMM one-page tracking sheet o PSPs for: • Individual #10, Individual #67, Individual #61, Individual #161, Individual #184, Individual #80, Individual #13, Individual #69, Individual #183, Individual #107, Individual #36, Individual #164 o CLDPs for: • Individual #14 (with all assessments and other attachments included) • Individual #164 (finalized CLDP submitted after being updated following CLDP meeting, updated assessments, and feedback from DADS) o DRAFT CLDPs for: • Individual #164, Individual #183 (no assessments were attached) o Pre-move site review checklists for: • Individual #14, Individual #164 o Post move monitoring checklists conducted since last onsite review for: • Individual #14: 7-day, 45-day <u>Interviews and Meetings Held</u>: o Antonio Ochoa, Admissions and Placement Coordinator o Alice Villalobos, Post Move Monitor o Jaime Monardes, Facility Director o Draco, Inc., community provider agency staff: Gisel Hita, program director, Christy Moody, home manager, Linda Ryan, LVN, Cindy Garcia, direct care staff; and the individual's parent/LAR who was present during the monitoring team's visit to the community home o Community Options, community provider agency staff (at CLDP meeting) o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs

	Observations Conducted: o PSP Meeting for: • Individual #169, Individual #5, Individual #43 o CLDP meeting for: • Individual #164 o Choice of provider meeting for: • Individual #132 o Community group home visit for: • Individual #14 o Preadmission meeting for • Individual #133 o Many residences and day programs at EPSSLC
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. In addition, during the onsite review, the APC reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the APC wrote a sentence or two about what tasks he had completed and/or the status of each provision item. For instance, 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 POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The APC self-rated the facility as being in substantial compliance with four provision items: T1c2, T1c3, T1h, and T2a. The monitoring team was in agreement with these self-ratings. In addition, the monitoring team rated the facility as being in substantial compliance with T1d, however, the facility rated itself as being in noncompliance. It was unclear from discussions with the APC and from a review of the POI how EPSSLC came to this self-rating. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Further, some action steps marked as completed continued to be rated as being in noncompliance by the monitoring team (e.g., page 129 #1, page 131 #1 and #2).

	Summary of Monitor's Assessment EPSSLC had not made much progress in meeting the provision items of T1. The facility, however, did continue to progress in meeting the provision items of T2. The lack of progress in T1 was most evident in the delayed, slow, and/or lack of activity taken to support, encourage, and assist individuals to move to the most integrated setting, especially once an individual was referred. The APC will need to take the lead in moving all of the processes along more quickly. The specific numbers of individuals who were placed and who were in the referral and placement process remained low, given the size of the facility. The monitoring team recommends that the facility's QAQI Council consider initiating a performance improvement team regarding most integrated setting practices and the components of this entire provision T. The monitoring team also recommends that the department's data be summarized and graphed every six months, and that the data be incorporated into the facility's QA program. The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and his staff work closely with the QMRP coordinator and the QMRPs to ensure this get implemented correctly. There was wide variability in the amount of information included in the PSPs within each subsection of the LOD. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability). Little work was done to educate individuals, their family members and LARs, and staff about the variety of community living and working options that might be available to individuals. Only one completed CLDP was available for review during the onsite review, however, a second CLDP was submitted following the onsite week after its finalization following the CLDP meeting held during the onsite week. The new process required that CLDPs be initiated at the time of referral. Thus, the CLDP should be an evolving document to which information is added throughout the referral and placement process. The list of essential and nonessential supports in the CLDP focused primarily on the provision of inservices and the scheduling of appointments. There were few supports that were directly related to actions that were to occur day to day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related

	to most integrated setting practices. As this develops, the APC and QA department need to ensure that they are looking at quality of the items on their tool, not just their presence (see Facility Self-Assessment above). Post move monitoring (T2a) was rated as being in substantial compliance. The post move monitor conducted post move monitoring in a thorough, individualized, and competent manner. The PMM's reports were very detailed and indicated that she observed and followed up on more than only what was specified in the CLDP. For example, rather than only monitoring whether an inservice occurred or an appointment was made, she conducted observations, interviews, and document reviews to look at implementation and competency of implementation.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Overall, EPSSLC did not make much progress towards meeting provision T of the Settlement Agreement. The lack of progress was most evident in the delayed, slow, and/or lack of activity taken to support, encourage, and assist individuals to move to the most integrated setting, especially once an individual was referred. Examples and comments are below: • Only 1 individual transitioned to the community since the previous onsite review. • The number of individuals on the referral list was 1 less than it was at the time of the previous onsite review. • During the previous onsite review, six months ago, the monitoring team attended a CLDP for Individual #164. He never moved and another CLDP meeting was held during this onsite review. The facility was unable to provide any reasonable explanation for this delay. Moreover, during this second CLDP meeting, the facility stated that he should not move until needed dental work was completed. This was going to delay his move even further, that is, a transition date could not yet be set. This seemed to be something that should have been taken care of months ago. Following the week onsite, the monitoring team was informed that the dental work was to take place on 7/21/11 and his move date was scheduled for 8/8/11. • Individual #31was referred by the PST during the previous onsite review during her annual PSP meeting that was, coincidentally, observed by the monitoring team. As of the week of this onsite review, no transition activities had occurred and the team was beginning to schedule tours of possible providers. • 6 of the 9 referred individuals were referred for more than 180 days. • Delays were not due to the community providers. They appeared willing and able to support the individuals on the referral list. They had bedrooms available and homes that were staffed. Moreover, if understood correctly by the	Noncompliance

		monitoring team, providers were absorbing the costs for staffing and housing while awaiting for the arrival of individuals from EPSSLC. Further, at the CLDP meeting during the onsite review, the provider was completely responsive to PST's request for there to be training objectives, the collection of implementation data during the 90 day post move monitoring period, and transportation to the individual's mother's home for visits. • EPSSLC had the capability to take more expedient and thorough actions regarding placement. For example, the PST for Individual #132 was embarking on a thoughtful and active plan regarding his transition planning and selection of provider. It is described below in section T1b1. Further, the CLDP for Individual #14 described an individualized process of visiting multiple providers and involving her in the choice of provider. The monitoring team recommends that the facility's QAQI Council consider initiating a performance improvement team regarding most integrated setting practices and the components of this entire provision T. Referral and placement activities continued to be overseen by Antonio Ochoa, the Admissions and Placement Coordinator (APC). He continued to be assisted by Alice Villalobos, the Post Move Monitor (PMM). The specific numbers of individuals who were placed and who were in the referral and placement process remained low, given the size of the facility. Below are some specific numbers regarding the referral and placement process. • Only 1 individual was placed in the community since the last onsite review (less than 1%). This was the same number (i.e., 1) as were placed at the time of the last review. During the baseline review, 3 individuals had been placed. • 9 individuals were on the active referral list as of 7/15/11 (less than 7%). This compared with 10 individuals who had been referred at the time of the last review, and 4 at the time of the baseline review. o 6 of the 9 individuals had been on the referral list for more than 180 days. • 2 individuals were described as having requested placement, but were not referred. For 1 individual, the LAR's preference was to not have the individual referred. The other individual did not have an LAR. o A facility review of each individual who requested placement, but was not referred (other than those for whom LAR preference was the sole reason) needs to occur. Lufkin SSLC had implemented this process and that might serve as a model for EPSSLC. It was called the "Placement Appeal Process" at Lufkin SSLC and is described in the April 2011 monitoring report for that facility.	

		• 1 individual was described as having requested placement, but was not referred due solely to LAR preference.
		  o The data for this category need to be gathered more accurately. This should be a list of individuals who would have been referred for placement but were not, solely due to LAR preference. This list should include not only those individuals who themselves requested referral, but those individuals who were not able to express themselves. This is a different list than the one described in the bullet immediately above, however, some names might appear on both lists.
		  o There were many individuals at EPSSLC who were likely to be on this list, such as two of the individuals who's annual PSPs were observed by the monitoring team.
		• 0 individuals were re-admitted to the facility after failed community placements.
		• The referrals of 2 individuals were rescinded since the last review. Some detail is provided below:
		  o Individual #54's 4/14/11 PSPA meeting notes indicated that he had serious medical issues that needed attention. Even though the referral was rescinded, the PST was moving forward in planning for his eventual re-referral. For example, he had visited a number of providers, and providers were discussing how to plan for his mobility and medical needs, as well as the possibility of living in the same home as his sister.
		  o Individual #85's 3/8/11 PSPA notes indicated that his referral was rescinded primarily because his sister was opposed to him moving. The PST expected that she would soon be appointed as LAR and, therefore, saw it as futile to continue referral activities even though the professional members of the PST appeared to believe referral would be appropriate for the individual.
		• 0 individuals were discharged under alternate discharge procedures (see section T4 below).
		• 0 individuals had died since being placed since the last onsite review.
		
		The above data should be summarized and graphed every six months. Each of the above eight bullets should be graphed separately. The monitoring team recommends creating simple line graphs with one data point representing six months of data (preferably to coincide with the onsite reviews, that is, January-June and July-December). These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team is available to help the facility create this graphic presentation prior to the next onsite review.
		
		In addition, the APC should do a review of every rescinded referral. Perhaps a thorough review might lead to changes in these processes for all, or some, individuals at EPSSLC.	

		Determinations of professionals This provision item 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. This is an activity that should occur during the annual PSP meeting and be documented in the written PSP. In the PSPs listed above under Documents Reviewed, a statement at the end of the PSP narrative attempted to present the PST's decision regarding most integrated setting and referral. These were typically one or two sentences that provided insufficient detail regarding the opinions of professionals on this important matter. Interestingly, in some cases, there was a statement that the PST members believed there were no barriers or obstacles, yet the PSP concluded with the statement that the team agreed that the current home at EPSSLC was the optimal living option at this time (e.g., Individual #67, Individual #184). Perhaps the upcoming proposed revisions to the DADS policy on most integrated settings practices and the living options discussion will set the occasion for the incorporation of professional's determinations. The facility should 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. In one PSP of the sample reviewed, two (i.e., not all) professionals' determination were written within the paragraph of that discipline's description of needed supports and services. This was for SLP and OTPT for Individual #80. Preferences of individuals EPSSLC appeared to work to honor the preferences of individuals. Preferences of LARs and family members EPSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. Senior management The APC reported that he had begun to inform senior management of the status of some of these data by sending a report to the facility director, assistant director of programs, director of quality assurance, and state office. This was the same format as during the previous onsite review. At that time, the monitoring team recommended that the APC model the weekly report on that of the Lufkin SSLC APC, called "Weekly Admission, Inquiries, and Referrals Update." The APC had obtained a copy, but had not yet made any changes to the report.	

		On the other hand, the APC had created a new log of information that may turn out to be relevant and useful. It listed every individual at the facility and included columns indicating whether or not he or she was referred, the individual's preference of living options (if it was expressed), the LAR's preference, and the CLOIP's recommendation. It was good to see CLOIP information listed in a single document. This will allow the APC to easily summarize the overall recommendations of the CLOIP (e.g., the number of individuals whom the CLOIP supports for possible referral). Interestingly, the majority of individuals for whom this section of the log was completed indicated that the CLOIP recommended that individual would do well in the community, that is, that it would be reasonable for the individual to be referred for placement (information was included for only about half of the individuals). The log was still in very early draft format and a lot of information was yet to be entered. Until it is accurately completed, however, it will not be very useful for data collection and summarizing. For example, the monitoring team noted an error: Individual #132 was noted as not being referred when indeed he had been referred. Further, the monitoring team suggested that a column be added to address whether the PST professionals' determinations regarding referral were adequately included in the PSP.	
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. The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. The APC reported that the facility followed the state's policy. The facility re-typed the state policy and labeled it as a facility-specific policy. The facility did not have any additional facility-specific policies. A revised state policy was in draft format. The Monitoring Panel had the opportunity to review this draft revised policy and submitted a set of comments to DADS separately from this report. The new policy contained improvements from the previous version as well as more detail for PSTs. Once finalized and disseminated, EPSSLC will need to incorporate these revised policies, practices, and forms into its facility-specific policies. Implementation of the new state policy and the updating of facility policies to make them in line with the new state policy will lead EPSSLC towards substantial compliance with this provision item.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be	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	Noncompliance

	provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	obstacles. The new statewide PSP policies and procedures were being implemented at EPSSLC. These policies and procedures were recently taught to the facility's QMRPs and the new procedures were put into place in late 2010. The facility was going to be providing additional training to QMRPs regarding their competency at facilitating the PSP meetings and the overall PSP process. DADS had recently contracted for consultation regarding the PSP process and QMRP facilitation skills. All three of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. In addition to attending PSP meetings, 12 recently completed PSP documents were reviewed (listed above in the Documents Reviewed list). The total sample included individuals representing different levels of referral for placement, ages, need for extensive supports, language abilities, medical needs, and family involvement. These 12 were chosen by EPSSLC, and sampled from each of the homes on campus. The new policy and procedures will require a more structured living options discussion to occur during the meeting and to be documented in the written PSP. This will require that the APC and his staff work closely with the QMRP coordinator and the QMRPs to ensure this gets implemented correctly. These activities had not yet begun, but need to begin as soon as possible. One activity that will need to be included is the APC attending a sample of PSP meetings to provide feedback to the QMRP and to participate, when appropriate. <u>Protections, Services, and Supports</u> The discussion about the ideal optimistic vision should focus on the components of an environment that would best (a) suit the needs and preferences of the individual, (b) ensure safety, and (c) provide adequate skill development and maintenance, and quality of life activities, such as leisure and recreation activities. The revised (but not yet finalized or disseminated) state policy included a more structured way of addressing the living options discussion (LOD) portion of the PSP meeting, both in the meeting and in the written document. Further, it separated the discussion of addressing the individual's preferences (which were derived from the PFW and discussed earlier at the PSP meeting) and the individual's needed supports and services (which were derived from assessments and discussed later at the PSP meeting during the LOD). The revised LOD will help ensure that the PST properly and fully considers an (a) optimistic living vision, (b) all aspects of supports and services, and (c) preferences.	

		The monitoring team observed all three annual PSP meetings held during the week of the onsite review. The air conditioning in the meeting room was improved from the time of previous reviews, making the setting much more comfortable and conducive to discussion. The three QMRPs observed were active, engaging, and working hard to facilitate the meeting, take notes, and in one case, translate the meeting in both Spanish and English. There was good attendance and participation from most, if not all, participants at each meeting. The QMRPs brought up community living in each meeting. For one, the LAR agreed to look at materials. For another, the family was pursuing legal status. For the third, the LAR was adamantly opposed to any consideration of referral even given the QMRP's appropriate and respectful questioning and requesting of the LAR. Even so, all of the QMRPs will require more practice and on-the-job feedback in order to conduct the type of integrated living options discussion required by the Settlement Agreement, the new PSP process, and the new living options discussion. For example, one of the three meetings was conducted in the old-style, that is, whereby each discipline provided a report, one at a time. The implementation of a thorough living options discussion will only be accomplished if the APC works closely with the QMRP department and the QA department. The set of 12 written PSPs reviewed were from March 2011 through May 2011. Comments on these 12 PSPs are below: • The narrative and action plan sections varied in length. There was wide variation in the amount of information included in the various sections of the document, including o the way in which the supports and services were written and formatted o the amount of detail included in the action plan objectives. Many of the PSPs included detailed descriptions of teaching procedures and data collection that were more appropriate for placement in the teaching plan (SPO). o EPSSLC needs to provide more guidance to QMRPs and PSTs as to what should be included in the PSP meeting and PSP document. This guidance should help the QMRP to determine what level of detail to include in each section of the written PSP. • The number of training objectives ranged from five (Individual #183) to 11 (Individual #13). This indicated that EPSSLC was focusing on teaching skills to individuals (also see section F and section S). • Three of the PSPs were for individuals who were referred for placement. During the previous monitoring review, the monitoring team reported that "the PST failed to take advantage of their limited time remaining at the facility to	

		intensely focus on the teaching of relevant skills for community living and independence." Some improvement was noted during this review, such as the inclusion of SPOs for walking on the sidewalk (Individual #164), making healthy food choices (Individual #61), and personal hygiene skills (Individual #183). Notwithstanding these examples, the overall sets of skills chosen, although improved, were not fully focused on helping prepare the individual for transition and life in the community. Statewide self-monitoring tools were being used across the facility. Three were developed for section T. Of these three, it appeared that only one was being implemented: regarding the living options portion of the PSP. Furthermore, it was implemented via observation of the PSP meeting at EPSSLC, whereas it was done by review of the written PSP document at other SSLCs. The state should clarify this for the SSLCs. The other two self-monitoring tools, for CLDPs and post move monitoring were not yet being implemented. Two completed self-monitoring tools were reviewed. They were both completed by the post move monitor. Ratings/scores were not provided, however, useful and pertinent comments were provided by the PMM. A document from the QA department indicated varying levels of interobserver agreement between the PMM and the QA department, however, not enough documentation was provided for the monitoring team to determine what it was that the QA department reviewed. Proper, reliable, and valid (i.e., correct content) self-monitoring will be required if EPSSLC is to achieve and maintain substantial compliance with all of section T. The monitoring team wants to recognize an outstanding example of the thoughtful and active development of one aspect of an individual's transition, that is, the selection of a provider, in this case, for Individual #132. A detailed write up was provided by the QMRP, Alex Euzaragga. The write up described the individual's visits to six different providers over a two-month period. It also included photos of the providers and a PSPA note describing the PST's selection of three of the six for further review. The further review occurred during the week of the onsite review and included an "interview" of each of the three chosen providers with the PST. The meeting was also attended by his outgoing guardian (CPS) and incoming guardian (DADS). After the interviews, the PST had a brief discussion and scheduled a meeting for the following week to discuss further and make a decision. The monitoring team was impressed by the QMRP's diligence and individualization of this process for this individual. Further, the write up described the visits in very good detail. The monitoring team recommends that DADS central office consider this an example of a best practice.	

		Obstacles to Movement There continued to be no coordinated plan or approach to identify and address obstacles to movement to the most integrated setting across the facility (also see T1g below). Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle (if one was identified) via an action plan as a service objective or training objective was not explicitly noted in most cases. As indicated in T1g below, the state will be requiring the PST to specifically identify obstacles to placement by choosing from 12 different categories. Wording in two of the PSPs indicated that this might be beginning to occur. In these cases, obstacles were described as "lack of support for people with significant challenging behaviors" and "availability of medical supports." It may be that use of this list will help PSTs to be more successful in identifying and addressing obstacles. It may be that PSTs will need to describe obstacles to referral separately from obstacles to making a placement happen (e.g., provider capability). The state's new system for determining and categorizing obstacles is likely to be helpful to PSTs. The new system should help PSTs to separate the defining of the supports and services the individual needs from the identification of obstacles that are preventing the individual receiving those supports and services in the most integrated setting. The obstacles from this set of PSPs indicated that all types of characteristics, situations, and conditions were given as obstacles. Some reflected preferences, others reflected the conditions and needs of individuals, and others reflected the perceived capacity and competence of community providers. As PSTs begin to define what supports are necessary to meet these needs, the discussion will likely become more centered upon what it is that the providers of community services will need to provide in order for the individual's placement to be successful, fulfilling, and long-term. To reiterate, obstacles, if there are any, will be identified later when PSTs attempt to arrange for the services/supports necessary to meet these needs and find that they are unavailable or cannot meet the individual's needs. It is important to note this distinction between needs and obstacles. Further, what were described as obstacles for most of the individuals was not consistent with any of the categories to be found in the state's new system for determining and categorizing obstacles. Please also see section F1e above for additional detailed discussion regarding assessment of preferences and needs, the optimistic living component of the PSP, skill training related to community living, obstacles, and referrals.	

	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 needs to do more to educate individuals and their families or guardians about community placements so that they can make informed choices. Although the facility had engaged in each of the activities listed in the DADS policy, the level of activity did not indicate continued progress towards meeting this provision item. The facility had only just begun to address education of individuals and their families on an individual basis. This was due to the PSP template requiring a comment about the education of the individual and LAR, however, as exemplified in each of the 12 PSPs reviews, the PSP provided very little information and no details. Some PSPs described what the individual had done, whereas others described what the individual might do during the upcoming year. The next step is for the PST to specifically report on (a) the activities of the previous year and (b) make a plan for the upcoming year. The annual provider fair was discussed in the previous two monitoring reports. EPSSLC had taken a unique approach to the provider fair, that is, by having the local providers present at the facility one at a time across the summer months. This had not yet occurred, but was being planned for August 2011. It did not appear that any of the recommendations and suggestions in the previous monitoring report were being considered. The previous monitoring report should be reviewed and these recommendations considered. Little activity had occurred with the local MRA authority. For instance, the longstanding monthly meeting had not occurred since February 2011. Training for staff was only recently initiated as part of New Employee Orientation. Specific training for management and clinical staff had not yet occurred (it was scheduled for 7/28/11). A Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) continued to be 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 CLOIP worksheet (i.e., report) was noted in T1a above. The CLOIP staff from the MRA need to take a more active role in the education of individuals and their LARs as evidenced in particular at the PSP meetings attended by the monitoring team (see F1e above). Taking individuals, staff, and PST members to visit community provider day and residential sites is a good way for everyone to learn more about the community options that are available. There was no organized system for this to occur at EPSSLC. There needs to be. It should include a process for including all individuals (unless the LAR and/or PST determines that tours should not occur), a way to determine what locations	Noncompliance

		should be visited by each individual, and a method to document that the tour occurred and the individual's response to the experience. There should be a way to track how many individuals across the facility had been on tours, how many were scheduled, and how many needed to be scheduled. The APC should incorporate data on tours into the admission and placement department's data, and include these data in the facility's overall QA data system, such as number of individuals who have gone on tours, number of providers visited, number of direct care staff who have gone on tour, and so forth (see section E above). At this time, the APC was not involved in the planning or scheduling of tours and he did not regularly receive reports about any tours that did occur. Finally, the monitoring teams and DADS central office are working towards agreement on the specific criterion for this provision item. Once established, it will provide more specific direction to the APC and the facility regarding achieving substantial compliance.	
	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 individuals were assessed by following the state's most integrated setting practices policy. The monitoring teams have been discussing this provision item at length with DADS, especially regarding whether the determinations of professionals in their discipline-specific assessments, a well-conducted living options discussion, and similarly well-done documentation in the written PSP, would meet the requirements for this provision item. This question will be resolved by the time of the next onsite review at EPSSLC.	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 Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	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. The monitoring team had the opportunity to review this new CLDP form a few months ago. These comments were presented in previous monitoring reports for this and other SSLCs. Many of these comments were taken into consideration and were reflected in the most recent draft proposed updates to the CLDP policy, practice, and forms. The monitoring teams have provided additional feedback and suggestions and it is expected that the new CLDP process and format will be disseminated and implemented sometime in the next few months.	Noncompliance

	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 directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. This necessarily required collaboration with the receiving community provider. As noted above, this policy, including the CLDP process, was being revised. The monitoring team reviewed the one CLDP that was completed since the previous onsite review (Individual #14). Two CLDPs that were in draft format were also reviewed (Individual #164, Individual #183), however, their content had to be considered incomplete (as also noted in the previous report) by the monitoring team and, therefore, not a representation of the facility's CLDP product. The facility, however, submitted a completed CLDP for Individual #164 two weeks after the onsite week, that is, after the APC finalized the CLDP following the CLDP meeting that was held during the week of the onsite review. The monitoring team appreciated that APC's effort to submit this completed CLDP. Going forward, however, the CLDP will become an evolving document that can be reviewed by the monitoring team at any point in the placement process. Therefore, during the next onsite review, the monitoring team should be able to review a larger set of CLDPs in order to assess compliance with all provision items related to the CLDP. This set will include the CLDPs for all individuals who will transition over the next six months as well as some (or perhaps all) of the individuals who are on the referral list. The CLDPs noted a great deal of inservice training that would occur for the community provider's management and direct care staff. That was good to see and it was well-documented. The CLDPs listed the sub-topics for many of these sessions. It should also specify what the expectations were with regard to the competency of the community provider staff in implementing the programs as well as their actual implementation of these supports. The CLDPs did not describe the need for collaboration between staff at EPSSLC and staff, consultants, or clinicians in the community. For example, it would be expected that clinical staff at EPSSLC would be responsible for sharing information and answering questions through face-to-face or telephone contact with their counterparts in the community. In none of the plans reviewed was this included as a requirement. This appeared particularly pertinent given Individual #14's complicated psychotropic medication regimen, individualized BSP, and complicated health concerns (e.g., skin care, gastrointestinal problems). The CLDPs indicated that the individuals had the opportunity to visit many providers and to do an overnight trial visit a week prior to the moves. Extended trial visits might also be considered by the PSTs as they plan for placements of individuals with a variety of	Noncompliance

		challenging behavioral, psychiatric, and medical needs. Monitoring activities were identified in the CLDPs, including the role of the MRA Local Authority, as well as the role of facility staff in the post-move monitoring and follow-up process. To reiterate, the new CLDP process should make the CLDP an "evolving document" that begins at the time of referral and "lives" until the individual is fully discharged from the facility, usually one year after moving to a more integrated setting. This was not yet in place at EPSSLC. Therefore, this process will be reviewed during the next onsite review. The plan, however, to make the CLDP available to all PST members and to initiate it upon referral was a good one and should contribute to meeting the requirements of this provision. The APC reported that DADS central office was conducting reviews of each of EPSSLC's CDLPs. The monitoring team reviewed this feedback for the completed CLDP and for one of the CLDPs that was still in draft format. This feedback should be helpful to the APC. Central office might consider reviewing CLDPs at various stages of development, not only at the point that the individual moves.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual and LAR review. This was also evident during observations of PSP meetings, the CLDP meeting, and discussion with Individual #14 and her mother while visiting the individual's new home in the community.	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 checklist of assessments was part of the new style CLDP and should help ensure meeting this provision's requirement. The checklist was used for both CLDPs reviewed. For example, Individual #14's CLDP contained 18 assessment summaries/updates. They were all completed within the 45-day period, with hearing and vision incorporated into the annual physical evaluation.	Substantial Compliance

		The CLDP for Individual #164 indicated that all assessments needed to be updated due to the delay in his move date to 8/8/11. The checklist in the CLDP was updated to include dates in mid-July for all assessments. The APC should ensure that the narrative in the CLDP also includes these new dates. 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.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The creation of the list of essential and nonessential supports provides the PST with the opportunity to ensure that the new provider provides the individual with all of the aspects of service and support that the PST deems necessary. PST members should never lose sight of their responsibility and opportunity, that is, that this is their chance to ensure that the individual gets what he or she needs and wants. Many PST members have, for many years, cared for, and cared deeply about, the individuals who are transitioning. They should take this opportunity to increase the likelihood of their individual's success at his or her new home. There are three components to a proper list of essential and nonessential supports. • First, the CLDP needs to include supports from a wide range of possible supports. This should come from the o individual's personal preferences and interests, o family members and LARs, o written assessments and updates from PST members (i.e., needed services for health, safety, and skill development), o other documents, such as the PSP and PSPAs, and o discussion at PST meetings, with attendance as required. • Second, supports, both essential and nonessential, need to be described in adequate detail, using observable, measureable, and verifiable terminology. The wording must provide the facility, the receiving provider, and the post move monitor with adequate guidance regarding the provision and monitoring of each support. • Third, the way in which provision of the support is to be verified must be provided. The CLDP needs to specify what should be observed by the post move monitor (e.g., paperwork, items, interactions with staff) and at what criterion (e.g., twice per week). The facility might also note that it remains available, perhaps even on an on-call basis, for any questions the provider might have regarding any support. The monitoring team reviewed the one completed CLDP and one draft CLDP (the essential/nonessential supports section of the other draft CLDP was not yet completed).	Noncompliance

		Below are comments on these CLDPs. • The lists of essential and nonessential supports contained requirements for staff inservicing in PBSPs, PNMPs, safety issues, and so forth. Nine of the 10 essential supports for Individual #14, and 10 of the 13 essential supports for Individual #164 were for staff inservices. o It would seem that the facility would want there to be a competency-based component to the inservicing. This should be considered for future CLDPs. • Although inservicing is very important, requiring only the documentation of the inservicing of staff and/or only the presence of the BSP or PNMP document is insufficient. o The required essential/nonessential supports should also list out those actions that the provider must implement to satisfy the post move monitor that these supports were being provided. o In these two CLDPs, the APC listed, in bullet-style format, some specific details required to be covered during each of these inservices. By providing this detail, the APC ensured that certain important information would be required to be included in the inservice. o Some, if not all, of these bulleted items should also be listed as essential or nonessential supports. • The lists of essential/nonessential supports were filled with the scheduling of appointments. In these CLDPs, the APC bulleted out a number of important points to be reviewed during the appointments (e.g., eight different bullets for the appointment with the PCP). This was good to see and provided the PMM with specific detail for her post move monitoring. • There were few supports that were directly related to the individual's preferred actions that were to occur each day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports. For example, only one of the essential and nonessential supports related to individuals' preferred activities; and this only referred to having an activity plan. One individual's preferred activity of bicycle riding was not included in the supports listed. • The CLDP feedback from central office can be very helpful. For example, the reviewers noted several supports that appeared absent from Individual #164's CLDP. The monitoring team also noted these when reviewing this individual's documents so it was good to see that the state's system was also catching these omissions.	

		One CLDP meeting was held during the week of the onsite review. It was for Individual #164, as noted above. The meeting was well-attended and included the individual's mother and the facility's medical director. Overall, there was good participation. The individual's mother reported that she was very happy and the community provider reported on the successful visits that had occurred. The SLP and the residential direct care staff manager provided useful comments. • The provider, Caring Matters, was very responsive to all of the requests of the PST, including expressing a desire to continue using whatever was working well at EPSSLC, such as the behavior support plan. They were agreeable to PST recommendations of using a wallboard for communication, implementing a training objective for sign language, and monitoring bowel movements. • The APC went through the CLDP page by page, assessment by assessment. This took too long and participation waned as the length of the meeting increased. After one hour, the APC was only up to page 21. The meeting lasted more than 2½ hours. • One of the most important parts of the meeting, the discussion of essential and nonessential supports did not begin until almost two hours had passed. As a result, it did not receive the thorough and dynamic discussion that is more typical in a CLDP meeting and that is required if the criteria regarding essential and nonessential supports described above are to be met. The APC should get guidance from central office about the format and flow of CLDP meetings. The facility had begun using a form entitled "Pre-Move Site Review," which was a part of the revised CLDP process. Two were reviewed and indicated that the essential supports (i.e., those required to be in place) were addressed. All of the essential supports, however, were inservicing. Therefore, the only activities that needed to be completed were inservice sessions. These may need to be re-done for Individual #164 by the time he actually moves after his dental needs are addressed. The pre-move review was conducted by the PMM and contained good and detailed comments.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. These reviewed the living options discussion at the annual PSP meeting, the CLDP document, and the post move monitoring documents. Implementation of these tools was just beginning at EPSSLC. The monitoring team's comments regarding these tools for this provision are above in section T1b1. The monitoring team recommends that the APC take a close look at these three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of the self-monitoring are adequate, and that the criterion for scoring appears to be valid.	Noncompliance

		In addition to the implementation of self-monitoring, data from the referral and placement activities at EPSSLC should be submitted to and incorporated into the QA program at the facility (see section E above). 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: • The bulleted items in T1a above • Individuals placed • Individuals referred • Obstacles to placement • Action plans related to obstacles • Educational activities • Number of providers, quality of providers	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the	At the facility level, EPSSLC was not in compliance with this provision item. EPSSLC was not gathering relevant information regarding obstacles across the facility. EPSSLC was not analyzing information related to identified obstacles to individuals' movement to more integrated settings. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. The proposed statewide obstacles report was described in the previous monitoring report for EPSSLC. As of the time of this review, it had not yet been issued and, therefore, the same comments from the previous monitoring report continued to be relevant and are not repeated here.	Noncompliance

	legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The monitoring team was given a document titled "Community Placement Report." It was updated 6/13/11. Although not yet included, the facility and state's intention was 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.	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two	EPSSLC was implementing the post move monitoring process. Post move monitoring was conducted by the post-move monitor (PMM), Alice Villalobos. Ms. Villalobos did an exceptional job of post move monitoring as indicated below. She was extremely	Substantial Compliance

	years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	thorough, organized, professional, and desirous of completing post move monitoring in an effective manner. Only two post move monitorings were required to be conducted since the last onsite review: the 7-day and 45-day for Individual #14. The two post move monitorings occurred within the required timelines and were completed using a form that met the requirements of Appendix C of the Settlement Agreement. The post move monitoring forms indicated that the PMM engaged in a very detailed review of every essential and nonessential support. What most impressed the monitoring team was that the PMM went above and beyond what was required by the CLDP to ensure that the individual was receiving proper supports. For example, as indicated above, much of the CLDP only required that inservices be conducted and that appointments be scheduled with healthcare providers. Rather than merely indicating that the inservice had occurred, the PMM: • Did observations of implementation (e.g., mealtime [support #1C]) • Interviewed staff to assess their knowledge (e.g., regarding medication [support #1E]) • Noted that the provider had created various monitoring and tracking forms to show implementation (e.g., skin care, bowel movement [support #1F]). • Inquired and followed up on each of the eight bulleted topics that were to be reviewed by the PCP (support #2A). • Did various checks of staff competency. The CLDP should have required these types of outcomes (i.e., evidence). Even though it did not, the PMM monitored for these competencies, implementation, and follow-up. Moreover, following a serious behavioral outburst that occurred during the first week of placement, the PMM called an emergency PST meeting to review the incident with provider staff and EPSSLC clinicians. Good discussion appeared to have occurred and an action plan with 12 components was developed. The PMM then followed up on implementation of each of these components. Overall, the post move monitoring forms included a lot of detail and description of the status of each support and the individual's overall experience in the community. The PMM created a one-page tracking list to monitor required deadlines for all post move monitoring. It fit onto one page because so few individuals had been placed. A rating of substantial compliance was given. Two items, however, need to be in place for the next onsite review: • There needs to be a specific yes/no determination made for each support.	

		• The facility needs to begin to hold a PST meeting following every post move monitoring visit, even if there are no serious issues.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team had the opportunity to accompany the PMM on a visit to the home of the individual who had moved to the community. This was not an official post move monitoring visit because the 45-day review had occurred during the weeks prior to this onsite review in order to meet the 45-day requirement. The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and nonessential supports. The monitoring team wishes to thank the PMM and the community agency for making arrangements for this visit to occur. Individual #14 lived in a beautiful home operated and managed by Draco, Inc. She was the first individual to move into the home; eventually there will be four. She appeared happy and settled into her new home. The program director, home manager, nurse, and direct care staff were present. The individual's mother also came by for a visit during this time. The monitoring team had the opportunity to talk with the provider staff and with the individual's mother about the transition, meeting of the individual's supports, and ways they could help the individual with the change in her relationship with her mother now that she lived in her own home rather than at EPSSLC. Overall, the provider appeared to be doing an exceptional job. The managers were highly involved and knowledgeable about the details of support provision for the individual. They had addressed the behavioral incident that occurred in May 2011 right after the move and were working towards continuing to meet all of the individual's needs. They were hoping that additional individuals would move in soon (also see T1a above) and were going to thoughtfully plan to support Individual #14 for when that occurs.	Not rated
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	This item does not receive a rating.	

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

Recommendations:

1. Create a performance improvement team for the provision items of T1 (T1a).
2. Implement updated DADS policy on most integrated setting practices, when it is disseminated (T1b)
3. Revise facility policies to be in line with the updated DADS policy (T1b).
4. Implement a process of review for each individual who has requested placement, but has not been referred (e.g., Placement Appeal) (T1a).
5. Identify those individuals who would have been referred except for the preference choice of the LAR; this list should include not only those who themselves requested referral, but those individuals who themselves cannot express a preference but whose PSTs would otherwise have referred (T1a).
6. Ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. Professional determination is separate from both the preference of the individual, the LAR, and the opinion of the PST as a whole (T1a, T1b1).
7. Implement the more-structured LOD as per the revised state policy (the APC will need to collaborate with the QMRP coordinator). Provide on the job feedback to QMRPs regarding their facilitation of the LOD (T1b1).
8. APC should attend the LOD portion of the PSP meeting and provide feedback and participate, as appropriate (T1b1).
9. Create more consistency in amount of information included in the LOD sub-section of the written PSP (T1b1).
10. Demonstrate individualization when skills are chosen for training objectives, especially for those who are referred for placement (T1b1).
11. Identify and address obstacles to referral and to placement at an individual level (T1b1).
12. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information (T1g).
13. Assess content and scoring criterion for the three self-assessment tools being used for this provision; and implement them in a reliable and consistent manner (T1b1).
14. In the PSP, describe what activities were taken over the past year, and what activities are to be taken during the upcoming year, to educate the individual and/or his or her LAR regarding community placement (T1b2).
15. Develop and implement a plan to improve the amount of activity related to education of individuals, LARs, and staff at EPSSLC, including, at a minimum, the provider fair, relationship with the local MRA, community tours, and trainings for staff (T1b2).
16. Summarize and graph all relevant data from the Admission and Placement department's activities (T1a, T1f).

17. Include Admission and Placement data in the facility's QA program (T1a, T1f).

18. Provide Admission and Placement department data and information to senior management (T1a).

19. Essential and nonessential supports should be chosen from a wide range, defined correctly, and evidence given (T1e).

20. When an inservice is listed as a support, it should also include competency outcomes (T1e).

21. The topics of inservices and appointments should be considered to be included in the list of essential or nonessential supports (T1e).

22. Ensure essential and nonessential supports specifically include the individual's most important preferences and the most important supports and services noted by the PST (T1e).

23. The APC should obtain guidance on the conduct, content, and flow of a CLDP meeting (T1e).

24. DADS CLDP reviews might be done at various stages of CLDP development, not only immediately prior to the move date. In addition, consider creating a metric to measure the quality of the CLDPs (T1c1).

25. Include a yes/no indication for each essential and nonessential support in the post move monitoring report (T2a).

26. Conduct a PST meeting following each post move monitoring visit (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o EPSSLC Plan of Improvement updated 7/1/11 o Human Rights Committee Minutes for the past six months o The facilities list of individuals determined to be priority I for need of guardianship. o Determination for Need of Guardian Priority Tool o Section U presentation book regarding progress towards compliance o List of individuals for whom an LAR had been obtained since 1/1/11 o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Personal Support Plans: • Individual #27, Individual #161, Individual #67, Individual #191, Individual #102, Individual #66, Individual #37, Individual #114, Individual #184, Individual #81, Individual #31, Individual #36, and Individual #13 Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QMRPs in homes and day programs; o Gloria Loya, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Morning Unit Meeting 7/11/11 and 7/14/11 o Incident Management Review Team Meeting 7/12/11 and 7/14/11 o Human Rights Committee Meeting o Annual PSP meetings for Individual #5 and Individual #43
	Facility Self-Assessment: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. In addition, during the onsite review, the HRO reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item.

	The facility assigned a noncompliance rating to both of the provision items in section U. It was unclear from a review of the POI how EPSSLC came to this self-rating. The monitoring team was in agreement with these self-ratings. The action steps included in the POI were restatements of the requirements of this provision. The facility was still waiting on approval of the state policy regarding consent and guardianship.
	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. Some positive steps that the facility had taken in regards to consent and guardianship issues included: • The facility had developed a list of individuals considered high priority for guardianship. • The facility had developed a list of guardianship providers in the El Paso area. • Local resources for obtaining advocates were explored • The Human Rights Committee continued to meet and review all restrictions of rights. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. While the facility maintained a list of some 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.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of	EPSSLC did not have a policy in place for developing and maintaining a list of individuals lacking both a 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 planned to take action in these areas once the policy is	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	finalized. At the last review, the facility did not provide the monitoring team with a prioritized list of individuals at the facility and their guardianship status. A list had been developed of individuals at EPSSLC who did not have a guardian. This list had been disseminated to all QMRPs. The facility now had a list of individuals determined to be priority I for need of guardianship by the PST. There were 39 individuals on this list. 85% of the individuals at EPSSLC had been rated for the need for guardianship. In 24 PSPs reviewed, there were 7 individuals (50%) who did not have guardians. The PST documented at least minimal individualized discussion regarding the need for guardianship in 14 of the 14 PSPs reviewed. For example: • Individual #114 did not have an LAR or active advocate. The PSP indicated that the team agreed he could not give informed consent and therefore, needed a guardian. He was referred to the HRO for guardianship 11/9/10. He was listed as a Priority I (high) for guardianship. There was no indication that action had been taken to seek a guardian for him. • Individual #184 did not have an LAR. The team had determined that she was unable to make decisions regarding her care. The PSP indicated that her sister-in-law advocated for her, so the team agreed that she was low priority for needing a guardian. Her sister had been mailed information on guardianship. If her sister-in-law is not interested in pursuing guardianship, the team needs to consider that Individual #184 cannot give informed consent and her sister-in-law cannot give legal consent. PSTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. The facility is not yet 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 and providing guidance on the	EPSSLC was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific policies to address consent and guardianship. The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. According to documentation provided to the monitoring team, there was one individual at the facility who had obtained a guardian since 1/1/11. Four individuals were listed as pending for guardianship indicating that family members had begun the process of pursuing guardianship. The facility did have some rights protections in place including an assistant independent	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	ombudsman housed at the facility and a rights officer employed by 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 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.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).

2. Continue to provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming an LAR (U2).

3. Continue to teach individuals to problem-solve, make decisions, and advocate for themselves (U1, U2).

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 (U2).

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 policy: Recordkeeping Practices (state policy with some facility additions) o Organizational chart, undated, but current o EPSSLC policy lists, 4/8/11 o List of typical meetings that occurred at EPSSLC o EPSSLC POI, 7/1/11 o EPSSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 7/11/11 o Tables of contents active records and individual notebooks, dated 2/4/11 o Table of contents for the master record, dated 2/24/11 o List of all staff responsible for management of unified records o Description of how documents flowed from completion to filing in records o New employee orientation sign in sheets recordkeeping practices sessions o Sign in sheets and related materials for QMRP and program developers training on recordkeeping o Description of SOAP procedures o Description of quality assurance auditing process o List of all individuals chosen for recordkeeping audits, five each month, January 2011 - June 2011 o 15 completed audits April 2011, May 2011, and June 2011; included the state self-assessment form and the facility's table of contents/guidelines form o Summary of QA department interobserver agreement on recordkeeping for two months o Various spreadsheets and emails regarding follow-up to the findings of the audits o A spreadsheet that tracked the status of state and facility policies for each provision of the Settlement Agreement o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 o EPSSLC description of how it addressed provision item V4 o Questions and answers regarding auditing and interviewing for this provision, from Becky McPherson to the SSLCs, dated 4/19/11 o Two V4 questionnaires completed at EPSSLC, for Individual #39and Individual #57 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 #16, Individual #84, Individual #75, Individual #72, Individual #6 o Review of master records of: • Individual #54, Individual #11, Individual #31, Individual #1, Individual #191, Individual #161, Individual #144

	Interviews and Meetings Held: o Priscilla Munoz, Medical Records Coordinator o Priscilla Guevara, Unified Records Coordinator 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: EPSSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. In addition, during the onsite review, the Medical Records Coordinator and the Unified Records Coordinator reviewed the presentation book for this provision. They had done a very nice job of organizing the presentation book and aligning documentation with each of the items of this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the MRC and URC wrote a sentence or two about what tasks were completed and/or the status of each provision item. Although this was helpful to the monitoring team, the monitoring team would prefer to have an understanding of the self-assessment process used by the recordkeeping department. For instance, 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. Further, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The MRC self-rated the facility as being in noncompliance with all four provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI were written to guide the department in achieving substantial compliance. The MRC reported that she developed the action steps from the previous monitoring report, their QA self-assessment forms, and discussions with department heads. The action steps, however, did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, all taken from this monitoring report, are set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation of an action, but a timeline that will indicate the stable and regular implementation of each of these actions.

	Summary of Monitor's Assessment: Overall, EPSSLC had made continued progress towards achieving substantial compliance with the items of this provision. Moreover, the medical records coordinator and the unified records coordinator were responsive to many of the recommendations and suggestions made in the previous monitoring report. They were working hard and had accomplished a lot since the last review. One of the their major accomplishments were the creation of a master record for each individual. Another was the regular implementation of five audit reviews of all three components of the unified record each month, and the recent initiation of feedback to managers and clinicians regarding any errors that were identified. Another was ongoing training and refresher sessions for all staff. The active records and individual notebooks were organized according to the required format, however, many were not as neat, thinned, or repaired as they should have been. This was most likely due to there being many different staff who were involved in filing and thinning (e.g., house supervisors, clinicians, overnight staff). Monitoring of all active records and individual notebooks was the URC's responsibility. The facility should explore additional ways of ensuring the quality of the active records and individual notebooks remains high. It is unlikely that the five monthly audits will, by themselves, be adequate in keeping the active records and individual notebooks at the quality where they need to be. Other areas for improvement were ensuring that all medical consultation documents were in the active record and that entries in the integrated progress notes were legible, with a legible signature, and with the clinician's credentials included. A complete set of state and facility policies had continued to grow since the last onsite review, but was not yet complete and comprehensive as required by provision V2. The facility indicated, on a spreadsheet, that status of the state and facility policies, however, EPSSLC did not appear to be following the state office's expectations for facility-specific policies (see details in V2 below). The conduct of quality assurance reviews of the unified record was another area where continued improvement occurred since the last review. Thorough reviews of all three components of the unified record were conducted by the unified records coordinator. Items needing correction were noted in the comments column of the review tool. A systematic way to provide PST members with feedback on corrections that were needed (e.g., missing documents, out of date documents) was not yet in place. EPSSLC had taken some steps towards ways to determine whether and how the unified records were used in making treatment decisions as specified in provision V4, including ensuring records were present at PSP meetings, conducting interviews of PST members, and increasing their skill at recognizing appropriate SOAP entries in the IPNs. More guidance is expected from central office over the next few months. The recordkeeping department was not, but now should be, collecting data on its own performance and submitting those data to QA to be part of the facility's QA program.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	EPSSLC demonstrated continued progress towards meeting substantial compliance with this provision item. The DADS policy remained in effect. The facility-specific policy on recordkeeping was the state policy with a number of additions. This appeared to be sufficient for recordkeeping operations at EPSSLC, however, the facility should consider adding the detail from the QMRP training (see below) into the policy. Recordkeeping activities continued to be managed primarily by the experienced and dedicated Unified Records Coordinator, Priscilla Guevara, and the Medical Records Coordinator, Priscilla Munoz. They were both very serious about their jobs, were committed to having acceptable unified records, and worked hard to do so. The MRC and URC: • Conducted new employee orientation so that new staff would be trained on recordkeeping practices; and they conducted refresher classes, too. • Conducted training sessions for all QMRPs and program developers regarding the new recordkeeping policies and practices as well as specific expectations based upon the table of contents/guidelines. This training included addressing recommendations from the last monitoring report. A regular session (perhaps monthly or every two months) with QMRPs and program developers might be very helpful to the facility. • Were responsive to the comments and recommendations in the previous monitoring report. The monitoring team recommends that the recordkeeping department begin to collect data on its own performance. To do so, the MRC and URC should list out the metrics that would be beneficial for their ongoing management of recordkeeping activities as well as be of interest to the facility. Examples include, but are not limited to: • Score on self-assessment tool • Number of records reviewed per month • Average number of items that required correction per individual unified record • Number of incomplete corrections after a specified period of time (e.g., one month)	Noncompliance

#	Provision	Assessment of Status	Compliance
		These data should then be incorporated into the facility's QA program. <u>Active records</u> The active records reviewed by the monitoring team were not as neat and well-organized as they should have been. This was most likely due to there being many different staff who were involved in filing and thinning (e.g., house supervisors, clinicians, overnight staff) because each department was responsible for handling its own documents. As a result many papers were misfiled, data for many sections had not yet been pulled from the individual notebook, many sections in the active record were overdue to be thinned and sent to the overflow files, and many papers were not properly inserted into the binder and, as a result, papers fell out, were folded, had ripped binder holes, etc. Monitoring of all active records was the URC's responsibility. The facility should explore additional ways of ensuring the quality of the active records remains high. It is unlikely that the five monthly audits (see V3 below) will, by themselves, be adequate in keeping the active records at the quality where they need to be. For instance, outdated/non-current documents (e.g., Individual #75 PSP quarterly review) and illegible signatures and entries were typical in many of the active records. On the other hand, the psychiatrist's consultation note from the previous day, however, was already in the active record for Individual #72. Apparently the psychiatrist wrote the note right after the psychiatry clinic and put it into the record right then. In addition, the state had improved the records by specifying (a) the minimum consent forms required and (b) more detail regarding what should be in the habilitation section. This was evident in the EPSSLC active records. EPSSLC had also improved the records in response to a recommendation from the last review. That is, they were beginning to include a listing of the SPOs so that it would be easier for the URC to determine if all SPOs were in both the active record and individual notebook. This was in place for Individual #16. More were expected over the next few months because they were being done after each individual's annual PSP meeting. Determining what medical consultation documentation should be in each active record remained a challenge because these varied from individual to individual (e.g., cardiac, podiatry, vision). The monitoring team suggests that the URC find out if the facility's medical department keeps a list of these consultations and, if so, whether a copy can be obtained every month for their use during record audits.	

#	Provision	Assessment of Status	Compliance
		Individual notebooks The DADS central office coordinator for recordkeeping practices sent a request for each SSLC to pick one of four individual notebook options. EPSSLC chose the option to keep the individual notebooks as they had been using them. This appeared to be a good resolution to the question about individual notebooks raised during the previous onsite review. For example, Individual #6's individual notebook contained his daily schedule, and relevant training materials in plastic pouches so that they were readily available to staff, such as restroom signs, paper money, and a pen. Similar to the comments regarding the active records above, the individual notebooks were all in place and being used, but because so many different staff were responsible for different portions of it, the individual notebooks varied in their organization, neatness, and clarity. For example, Individual #75's individual notebook had PNMP data sheets going back to November 2010 and observations notes back to April 2011. These should have been removed and placed in the active record by now. The facility will need to demonstrate that data and information are accurately and reliably recorded. The monitoring team believes that this was also a requirement of DADS central office (also see section K above). EPSSLC should be prepared to discuss this during the next onsite review. Master records The recordkeeping staff had created a master record file for every individual. This was an accomplishment since the last onsite review. Reportedly, the facility worked with the Richmond and San Angelo SSLCs in learning how to set up the master record. A standard table of contents was used for the EPSSLC master records. Master records were reviewed for seven individuals, including some who were recently admitted and some who were residents at EPSSLC for many years (Individual #54, Individual #11, Individual #31, Individual #1, Individual #191, Individual #161, Individual #144). The master records were very organized, very neat, and easy to review. Now that EPSSLC had master records and a checklist table of contents, it was evident that many items on the list were not available. The next step is for the facility to determine what to do about the many items that are missing. The recordkeeping staff should have some sort of procedure or rubric to follow so that they are ensuring that they are doing follow-up on any documents that should be located. Perhaps state office can provide some guidance to the MRC and URC.	

#	Provision	Assessment of Status	Compliance
		Overflow files Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
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. The monitoring team was very pleased to see the organized and systematic way that state office was going about managing facility-specific policies, that is, state office: • Required a facility-specific policy (or policies) for every Settlement Agreement provision • Required each facility-specific policy to be in line with the contents of the state policy • Required the facility to submit each facility-specific policy for approval • Provided feedback on the content of each facility-specific policy • Detailed these expectations in an email memo from the DADS SSLC director of operations, dated 3/15/11. These specific steps were not yet being implemented at EPSSLC for the facility-specific policies. This provision item was primarily managed by the QA director. A spreadsheet submitted to the monitoring indicated the wording "Adopted state policy and localized it." This did not provide sufficient information as to what was done (i.e., whether there an additional facility-specific policy or did they solely use the state policy) and whether the processes detailed in the 3/15/11 DADS email memo were being followed. Some facilities have created a second spreadsheet to detail the status of each facility-specific policy. EPSSLC should consider doing the same.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random	Reviews of five unified records had begun a few months ago at EPSSLC. Most recently, the individual notebook and master record were included in these reviews. This demonstrated continued progress. The review/audit system appeared to be thorough, though the URC was still becoming comfortable with conducting these audits. Each audit took three to four hours to complete. The five names were randomly generated from the data analyst using some sort of random selection process. Fifteen audits were reviewed by the monitoring team (i.e., five each for April 2011	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	through June 2011). For each audit, the URC used both the self-assessment tool and the table of contents/guidelines checklist. This latter checklist was more detailed and appeared to be more useful than the self-assessment tool. Further, the URC used information gathered from the table of contents/guidelines checklist to help her complete the self-assessment tool. She recorded many notes and comments as she conducted the TOC/guidelines checklist. The QA department should consider doing occasional interobserver reliability checks using this tool, too, that is, not only using the self-assessment tool. Further, the self-assessment tool data were entered into the QA system. The TOC/guidelines, however, might prove to provide more useful information to the facility. Further, the items in self-assessment tool were very broad and somewhat ill-defined, so it was not surprising to see that there were low QA interobserver reliability findings for the two months reported to the monitoring team (January 2011 and February 2011). Calculating interobserver agreement on the TOC/guidelines might result in better interobserver agreement. A system to manage the results of these audits had only begun in late May 2011. It consisted of a lengthy spreadsheet that listed each of the errors that were found by the URC. It also included a column as to the status (e.g., "corrected," "Matt Rivera notified"). The URC also emailed the respective manager or clinician regarding any needed corrections which included inviting him or her to come to the recordkeeping office to discuss. Overall, the URC reported that she had a good response from those whom she emailed. This was a good start for the URC, but a more organized system of managing errors and corrections will be needed as she moves forward. It will need to include, for example, how to determine whether a correction was made and how long to follow uncorrected errors. In addition, the URC should do some sort of summarizing of the data from the reviews in both a graphic/tabular format and in a short narrative that describes the highlights of the data. Moreover, the information should be tracked and trended over time and included in the facility's QA program. The information should include, for example, number of reviews conducted, number of items that needed correction, and number of outstanding corrections (see V1 above).	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four	Work will need to be done to determine what activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. Recently, the monitoring teams presented, to DADS and DOJ, a proposed list of actions for the	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	SSLCs to engage in to demonstrate substantial compliance with this provision item. Even so, the recordkeeping staff had implemented some processes towards this end. First, the URC conducted two post-PSP interviews of PST members using the new questionnaire form developed by central office. Each of these two questionnaires included brief interviews with six different PST members. Thus, the two completed questionnaires contained some very interesting and potentially useful information that the facility might be able to use to (a) understand how the records are used, and (b) demonstrate how the records are used to satisfy, at least in part, the requirements of this provision item. The facility, however, had not yet done anything with these results. Second, all volumes of the active record and the individual notebooks were present at all PST meetings observed by the monitoring team during the week of the onsite review. This made the records accessible to PST members during important discussions. Third, the recordkeeping staff had attended some PSP meetings to observe use of the records. Although laudable, this was not a good use of the recordkeeping staff's limited time. Perhaps observation of presence and use of records during PST meetings can be incorporated into one of the other PSP meeting observation tools. Fourth, the recordkeeping staff became more knowledgeable about the SOAP entry style so that they could more competently review the IPNs. 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. • Individual notebooks were readily available to staff. The staff reported that the individual books were helpful. The monitoring team observed DCPs using the individual books. • During observations by the monitoring team, across the dorms and cottages, a number of the active records were missing from the shelves for extended periods of time and unavailable to be utilized by the nurses in making care and treatment decisions. • Medical providers made entries in the records. These were not seen in response to some issues, such as consults and QDRRs. Pharmacy policy also required the medical provider to note in the IPN when a severe drug interaction was reported. There were several instances when this was required, but documentation was not found in the records. • IPNs were not consistently done in SOAP format, were sometimes illegible, and often had unrecognizable signatures and credentials. Since the prior monitoring review, the legibility of nurses' notes, signatures, and credentials had continued	

#	Provision	Assessment of Status	Compliance
		to decline. • In all four observed psychiatric clinic encounters, the individual's record was available and the physician was actively reviewing documents. The psychiatric nurse provided the physician with laboratory data and the most recent MOSES/DISCUS data for review during the encounter.	

Recommendations:

1. Consider adding information from the trainings conducted by the recordkeeping staff into the facility-specific recordkeeping policy (V1).
2. Consider holding a regularly occurring session (perhaps monthly or every two months) with QMRPs and program developers regarding recordkeeping (V1).
3. The recordkeeping department should begin to collect data on the facility's recordkeeping activities and the department's performance (V1).
4. Incorporate all of these data into the facility's QA program (V1, V3, V4).
5. Explore additional ways of ensuring the quality of the active records remains high (e.g., filing, thinning, loose papers, legibility) (V1).
6. Determine what medical consultation documentation should be in each active record. Find out if the facility's medical department keeps a list of these consultations and, if so, whether a copy can be obtained every month for use during record audits (V1).
7. Explore additional ways of ensuring the quality of the individual notebooks remains high (e.g., filing, thinning, loose papers, legibility) (V1).
8. Determine what to do about the many items that were missing from the master record (V1).
9. Follow the steps outlined by DADS central office regarding facility-specific policies (V2).
10. Consider creating a second spreadsheet to detail facility-specific policies and their status for each provision of the Settlement Agreement (V2).
11. The QA department should consider doing occasional interobserver reliability checks using the Table of Contents/Guidelines tool (V3).
12. An effective system to manage the results of the monthly unified record audit reviews needs to be developed and implemented (V3).
13. Implement all procedures to address V4 when disseminated from state office.
14. Discontinue having recordkeeping staff attending entire PSP meetings if they were doing so only to observe the use of the unified record. Instead, incorporate these observations into one or more of the other PSP meeting observation monitoring tools (V4).
15. Summarize and use the information collected from the post-PSP meeting PST interviews (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACE	Angiotensin-Converting Enzyme
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACP	Acute Care Plan
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
ANC	Absolute Neutrophil Count
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
ARDS	Acute respiratory distress syndrome
ASA	Aspirin
ASAP	As Soon As Possible
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider

AUD	Audiology
BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMax	Concentration Maximum
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services

CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DDS	Doctor of Dental Surgery
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Doctor of 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
DX	Diagnosis
e.g.	exempli gratia (For Example)
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FNP	Family Nurse Practitioner
FOB	Fecal Occult Blood
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow Up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide

HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder

L	Left
L	Liter
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education
Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MI	Simethicone Gas Relief
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging

MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NL	Nutritional
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light

PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
Pharm.D.	Doctorate, Pharmacy
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PLTS	Platelets
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 Oximetry
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)

QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RR	Respiratory Rate
RTA	Rehabilitation Therapy Assessment
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TED	Thrombo Embolic Deterrent
TG	Triglyceride

TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TT	Treatment Therapist
UA	Urinalysis
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VPA	Valproic Acid
VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WT	Weight
XR	Extended Release
YO	Year Old